SBH

Operations Manual

School Behavioral Health Programs

Operating Procedures for a School Behavioral Health Team in Military Impacted Schools

August 31, 2011

Child, Adolescent & Family Behavioral Health Office (CAF-BHO)
United States Army Medical Command (MEDCOM)
Office of the Surgeon General (OTSG)
United States Army

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I. MANUAL PURPOSE AND ACKNOWLEDGEMENTS

The overall goal of the Unites States (U.S.) Army's School Behavioral Health (SBH) initiative is ***to facilitate access to care by embedding behavioral health (BH) within the school setting, and to provide state of the art prevention, evaluation, intervention, and treatment through standardization of SBH services and programs***. In addition, specific procedures related to a full array of effective programs and services, reflecting a three-tiered model of health promotion/prevention, early intervention and treatment will be implemented at the installations.

The Child, Adolescent and Family Behavioral Health Office (CAF-BHO) of the U.S. Army developed this manual for three primary purposes: 1) to assist installations in more rapidly building SBH programs and services, 2) to increase the likelihood that these services are effective in achieving valued outcomes, including improving student school success, military family adjustment, and Soldier readiness, and 3) to promote standardization in implementation and evaluation across sites to help increase the capacity and impact of the initiative. It is also hoped that the guide helps to promote collaboration of stakeholders to include Installation Management and Medical Command, departments of education of local school districts serving military students, and other youth serving systems such as BH, child welfare, and social and juvenile services.

Initially, the manual was developed as a guide by the Hawaii SBH Team, at Tripler Army Medical Center (TAMC) in 2008. In 2010 a process began to write a more general manual that would standardize approaches to SBH across the Army.

Special appreciation is extended to the University of Maryland School Mental Health Program and Center for School Mental Health (CSMH), the University of South Carolina (USC) School Mental Health Team (Department of Psychology), the Tripler Army Medical Center SBH Health Team, the Joint Base Lewis-McChord SBH Team and the CAF-BHO SBH Manual Team for developing and sharing numerous resources highly relevant to the development of the manual.

II.BACKGROUND, MISSION, GUIDING PRINCIPLES AND CORE ELEMENTS

Background

Impact of Deployment on the Behavioral Health of Military Dependents

Deployments to Iraq and Afghanistan have affected nearly two million military children. Since the onset of Operation Enduring Freedom (OEF) in 2001, over 3,700 military Children (under the age of 18 years old) have lost a Service Member parent and over 41,000 have experienced a parent who was wounded, injured or ill.[1]

Research shows that children who experience the deployment of a parent are affected by greater adjustment difficulties, increased responsibility and support of the "at home" parent, and with feeling as if their experience is not something that is comprehended by the surrounding community. [2] They consistently demonstrate higher levels of emotional difficulties and symptoms of anxiety. Recent studies have indicated that many children not only experience heightened anxiety during the Active Duty parent's deployment but continue to exhibit symptoms of anxiety after the deployed parent returned home.[3]

Children's adjustment to deployment varies by a number of factors including, but not limited to, age, developmental stage, family composition, length of deployment and other individual and family factors. Recent research also suggests that a child's adjustment was directly tied to the level of parental distress observed over the course of the deployment.[3] Consistently, children of deployed parents face significant difficulty with overall adjustment, including "externalizing" behaviors (aggression, noncompliance), and "internalizing" behaviors (depression, anxiety, irritability).

Young children may exhibit regression in developmental milestones (such as bedwetting and thumb-sucking), while older school aged children may show decline in academic performance and increase in depression and behavioral problems in response to emotional stress. [4] Although all children are impacted in some way (either good or bad) by the deployment of a Parent or Parents, the literature suggests that young children (infants and preschoolers) are still the most impacted by parental deployment.

A 2008 RAND Study (2008)[1] confirmed that recent and frequent OEF/OIF deployments have a negative impact on child and adolescent behavior and behavioral health outcomes. Children indicated that they experienced significant difficulties with readjustment when a parent was both deployed and returned from a deployment. Children endorsed having difficulty interacting with peers and teachers who had limited understanding of what their deployment experiences were like.

Department of Defense (2010). Report on the impact of deployment of members of the armed forces on their dependent Children.

2 RAND (2009). Views from the homefront: How Military youth and spouses are coping with deployment

3Patricia Lester, Kris Peterson, James Reeves, Larry Knauss, Dorie Glover, Catherine Mogil, Naihua Duan, William Saltzman, Robert Pynoos, Katherine Wilt, William Beardslee. (2010). The Long War and Parental Combat Deployment: Effects on Military Children and At-Home Spouses. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49 (4): 310-320

4 Department of Defense (2010). Report on the impact of deployment of members of the armed forces on their dependent Children.

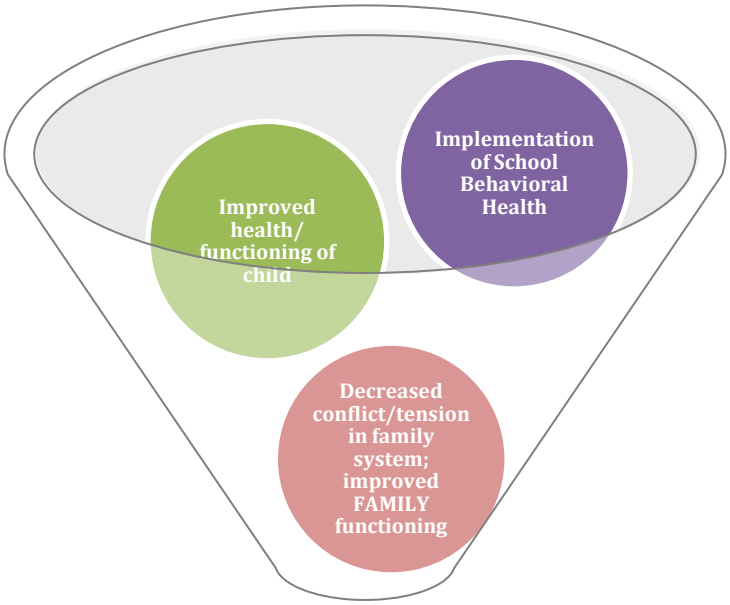
5 RAND (2008). Understanding the impact of deployment on Military Families.

This only begins to examine the challenges that Military Children face when adjusting to extended and frequent deployment of a family member. It is apparent that there is an emergent awareness of the unique BH needs of Military Children in both addressing emotional and adjustment difficulties and in targeted intervention for building resilience. One such delivery model spanning the continuum of health promotion and intervention is SBH.

School Behavioral Health (SBH)

School Behavioral Health (SBH) is a federal and national priority in the United States (U.S., see President's New Freedom Commission, 2008; Weist, Evans & Lever, 2003; Evans, Weist, & Serpell, 2007), and is an emerging priority for the Military. (see Faran et al., 2003; Faran, Weist, Faran, & Morris, 2004). SBH programs are being developed in conjunction with the implementation of other child and family programs coordinated by the CAF-BHO at Joint Base Lewis-McChord (JBLM). It is increasingly recognized that these programs are ***critical in maintaining a healthy family unit in the context of Army Families and Soldiers experiencing the effects of prolonged war and high operational tempo***. A substantial need exists to develop a ***system of BH care*** **that** ***supports Soldiers and their Families throughout the Army Force Generation (ARFORGEN) cycle and also in relation to school, life cycles and transitions***.

Outcomes & Soldier Readiness



Increased capacity for SOLDIER to tolerate stress; improved functioning (*Soldier Readiness*)

Improved FORCE READINESS

Mission

Implement a cost-effective comprehensive array of SBH programs and services to support Children, their Families, and the Army community at the Schools and Child Development Centers directed at the promotion of optimal Soldier readiness and Army Family wellness and resilience.

Guiding Principles

This initiative incorporates research developed principles designed to assure the highest quality SBH prevention and intervention:

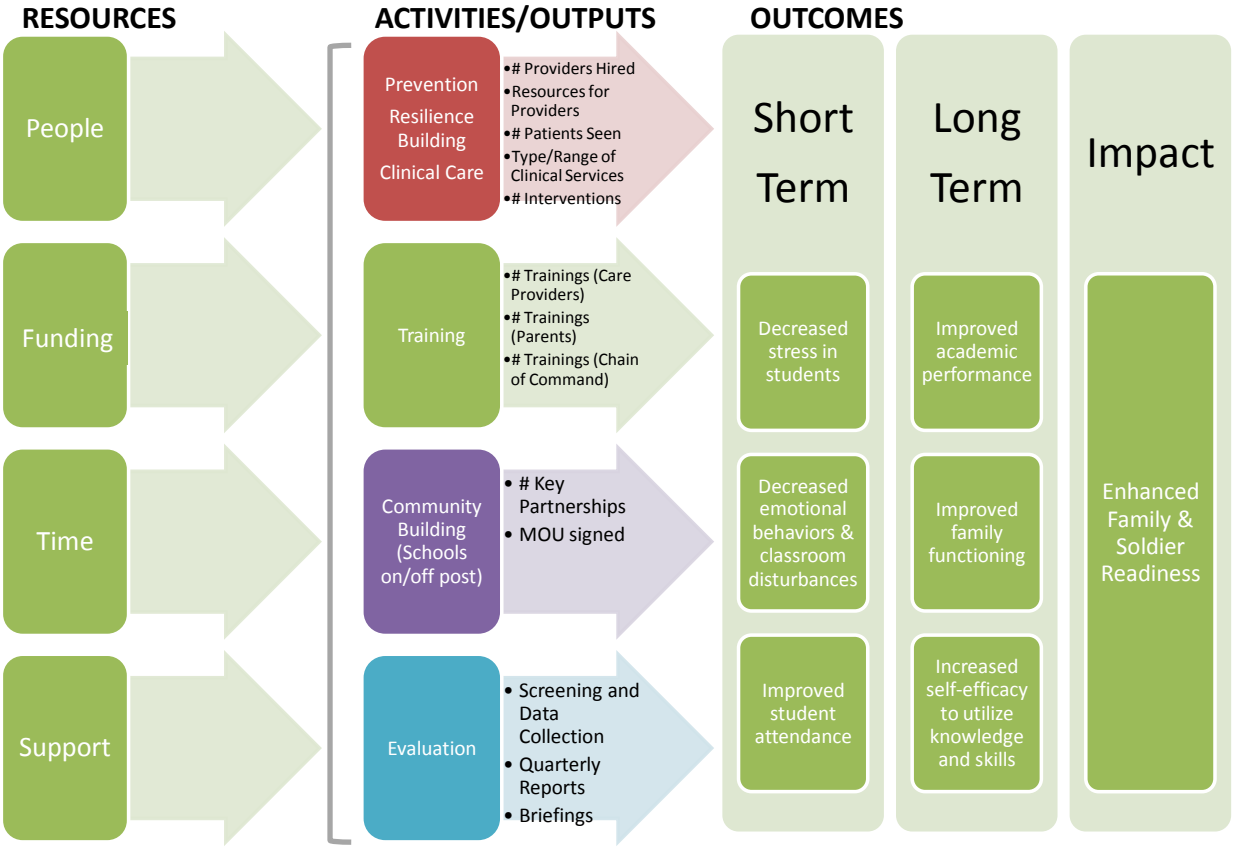
- An **inclusive approach** reaching out to and assisting all interested youth and Families, to purposefully overcome barriers to behavioral health intervention
- Establish programs in ways that are **responsive to** student, school and Military community **needs**, while **building on strengths**
- Focusing on **reducing barriers to student learning** through programs that are student and family friendly and that **stem from evidence of what works**
- Proactively **involving all interested stakeholders** in program development, improvement and growth
- Emphasizing and providing support for systematic ongoing **quality assessment and improvement**
- Ensuring the **full continuum** of BH resources and support
- Hiring the **right staff**, who receive the **right training** and **ongoing coaching and support** in delivering preventative services and evidence-based interventions
- Assuring that all efforts are **sensitive** to the full range of **developmental, cultural/ethnic**, and personal circumstances of students
- Building **interdisciplinary relationships** in schools and **strong teams**
- Building **strong connections** between programs and resources **within the school and resources in other community settings** (Weist et al., 2005).

The initiative recognizes that **positive collaborative relationships underpin all successful efforts**. There will be a constant focus on building these relationships among school staff, Military Families, other health and mental health staff, and other stakeholders. There is a commitment to **continuous quality improvement in all realms**, including the full range of prevention to intervention services and evaluation processes.

Core Elements of the SBH Logic Model

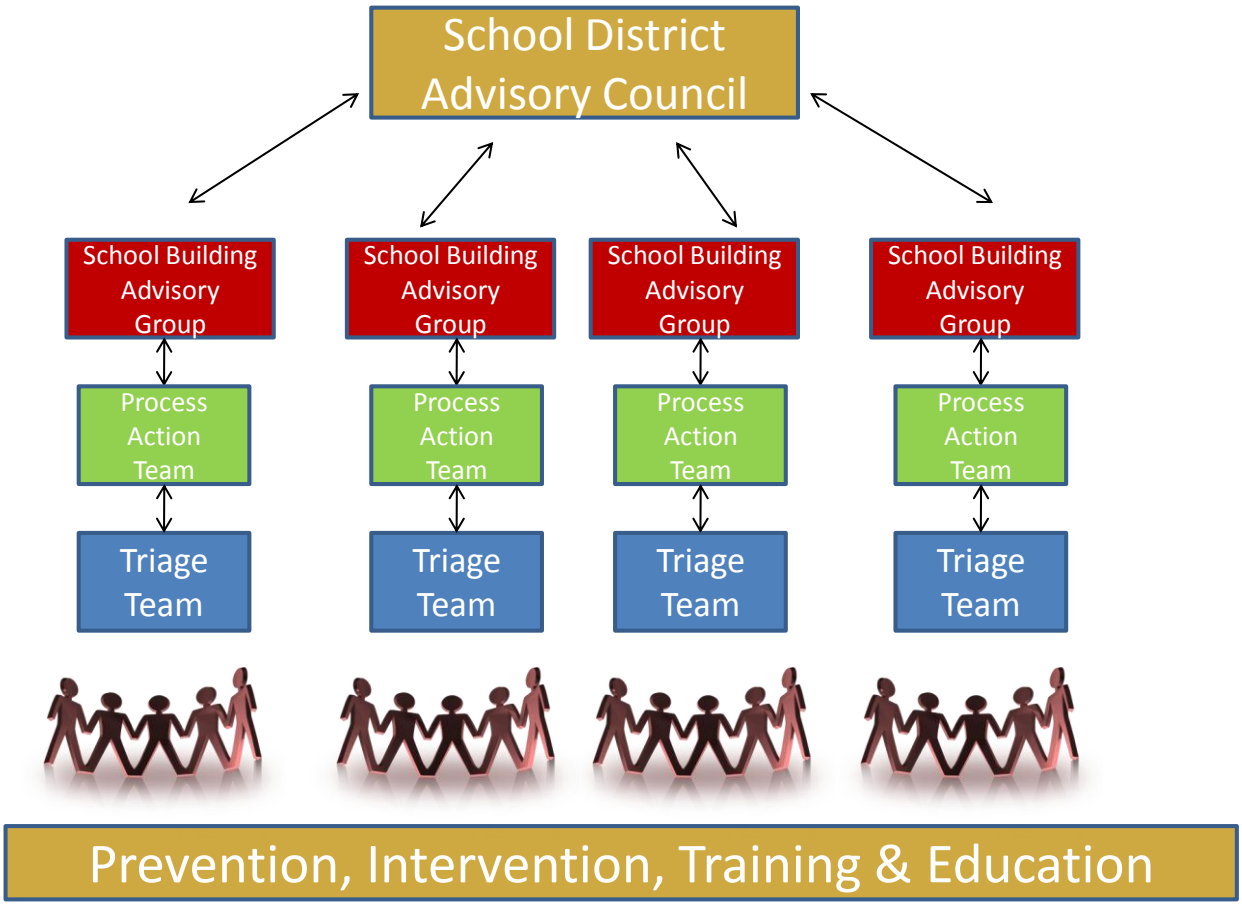
Implementation of SBH will be facilitated by the CAF-BHO, working closely with SBH staff at each installation. A **National Advisory Board** comprised of Army leaders, experts in child, adolescent, and family mental health, SBH, education, and family advocacy will provide oversight and recommendations. The National Advisory Board will meet yearly in conjunction with an Annual National Conference on SBH and pre-conference on Supporting Military Families. The Board will meet two or three additional times each year through teleconference. The CAF-BHO will develop a **National Community of Practice on BH for Military Families** that will promote communication and collaboration among leaders and staff involved in SBH. At each installation, the following core elements of SBH are expected to be in place.

SBH Logic Model



1. **Coordinated and integrated** SBH services and programs with **easy and simple access to care**
2. Educational and other strategies designed to **decrease stigma** in seeking BH assistance
3. Established leadership for newly created SBH programs through memorandums of agreement (**MOAs**) between the Medical Treatment Facility (MTF) and local school districts (see Appendix pg. 47)
4. A School District **Advisory Council,** with quarterly meetings, chaired by an Installation leader (or designee) and the District Superintendent(s) (or designee) to evaluate progress and institute new initiatives or major changes in program direction
5. An **Advisory Group** chaired by the Site Director or Deputy Director and the School Principal or Assistant Principal (or designee) at each school to assure strong programming and responsiveness to the school's needs and priorities, with monthly meetings
6. A **Triage or Student Support Team,** with weekly meetings, at each school co-chaired by the clinician assigned to that school and the Principal or designated school-employed mental health professional (e.g., psychologist, counselor, social worker) to both discuss the treatment plan and progress of students and Families receiving services, and to analyze and continuously improve program operations
7. **Standardized implementation of actions in this Manual at each installation**, with active support from the Director of SBH and staff at CAF-BHO for effective implementation, continuous quality improvement
8. Completion of **Quarterly Reports & other outcome data collection** and measurement processes

School Behavioral Health Organizational Structure



Advisory Board: Regional. Provides overall guidance and direction, quality assurance.
Advisory Group: At each school. Provides specific advice to the SBH program, policy development, performance improvement. Ensures effective collaboration of all care providers.
Triage Team: At each school. Responsible for clinical case/problem review – referral, management, monitoring.

Key features

-- Early detection
-- Care and prevention provided onsite where the child is located
-- Integrated efforts; complement to School Liaison Officers, Military Family Life Consultants, School Counselor
-- Opportunities for training and education

School Behavioral Health (SBH) Program Goals

The overarching goal of the SBH Program is to facilitate increased access to care by embedding BH within the school setting, and to provide state of the art prevention, evaluation, intervention, and treatment through standardization of SBH services and programs. In addition, the following specific program goals, related to a full array of effective SBH programs and services, will be achieved:

Goal 1: Enhance school climate and broadly promote behavioral health, wellness, and school success for students, Families and staff by conducting on-going needs assessments, building relationships and systematically seeking to reduce stigma.

Goal 2: Deliver a range of health promoting and preventive interventions, including those focusing on resilience, wellness and effective coping with stress for Military Families

Goal 3: Deliver a range of effective interventions to Military Families to address emotional and behavioral concerns and the unique stressors of Military life through the delivery of training, implementation of evidence-based practices and effective clinical case management

Goal 4: Ensure high quality, evidence-based prevention, intervention programs and services will be effectively delivered, evaluated and continuously improved through the use of standardized measures and outcomes

Goal 5: Conduct training and build school community support for delivery of effective SBH to Military Families

Goal 6: Expand and improve SBH services for Military Families through organized advocacy and policy influencing actions

For additional information on these goals and the specific strategies see *Section VII: Program Goals and Action Strategies* of this Manual.

III. BUILDING PARTNERSHIPS AND ASSURING ACTIVE STAKEHOLDER GUIDANCE

Partnerships

The SBH program should operate within Military impacted schools. Program leaders should take into account documented need, level of readiness, resources and program experience in determining appropriate schools. New initiatives should start with the schools on Army Installations or serving the highest percentage of Military Students and Families.

At each installation SBH should represent a partnership among school leaders and staff, Army leaders and staff, Families, and community leaders and representatives in addressing **a shared agenda** (see Andis et al., 2002), education and well-being of students. Building, growing and strengthening relationships associated with this partnership will underpin the success of the SBH effort. Building and growing the SBH program at each installation will be guided by a school district level Advisory Council and school Advisory Groups, described here.

The **Advisory Council** provides overall guidance in the program's development, continuous improvement and expansion. It should meet quarterly, with ongoing email among Council members. The Council will help the program connect to relevant military community initiatives, and will monitor and assure the quality of program services. Please note that the Council is advisory, not governing, but program leaders should strive to integrate Council members' recommendations actively into program operations and development. The Council should be chaired by a leader from the Installation and by the school Superintendent, Assistant Superintendent (or designee). There are no term limits for the Council chairs or for members, but every two years there should be self-assessment by all members of their ability to actively contribute, with associated adjustments in Council membership.

Additional Advisory Council Members may include:
local government officials, business representatives, civic organization leaders, law enforcement officials, medical professionals, community mental health providers, faith-based leaders, parents, and interested military and civilian youth.

In addition, each school should have an **Advisory Group** that will be chaired by the Site Director or Deputy Director and School Principal, Assistant Principal (or designee). This group should meet monthly and will provide overall guidance on improving the SBH program's functioning and impact.

All Advisory Council and Advisory Group meetings should be well organized and facilitated, with notes taken and disseminated to participants and non-participants. Meetings should be held at convenient locations and times, and meeting facilitators should focus on the group process (e.g., staying on task, not allowing side tracking or dominating). Ideally, meetings will have refreshments and will be lively and interactive.

Additional Advisory Group Members May Include:

School Counselor
Teacher
School Behavioral Health (SBH) Practitioner
Parent of Student at School
Parent of Student at School (Ideally, One Who Is Well Networked)
Commander of Brigade with Oversight of That School and/or Active Duty Parent
Representative from Army Community Services
Representative from School-Aged Services/Teen Center associated with school
Military Family Life Consultant (MFLC)
Student Liaison Officer (SLO)

Establishing SBH in the Local Community

As the SBH program is beginning or developing at installations, the CAF-BHO with the Director of SBH in a lead role, will work closely with the site in helping to establish the program and guide its improvement and growth. This will include hiring the Site Director, and assisting the Site Director in developing the team, including Deputy Director, Administrative Officers and clinical staff. As these staff members are hired, there will be a **major emphasis in early months on developing relationships** with school principals, school-employed mental health and health staff, teachers, involved parents and family members, Military Family Life Consultants, and School Liaison Officers. The CAF-BHO will also help establish the above mentioned Advisory Council and Advisory Groups at each school. One of the first tasks will be conducting a **needs assessment at each school** including key informant interviews and focus groups (see Appendix pg.60 for a list of key questions) with key stakeholders. Included in the needs assessment should be **resource mapping** of existing staff and programs, in the school, that can be integrated into the SBH effort.

Memorandum of Agreement

All programs should develop a **Memorandum of Agreement (MOA)** between local school districts or state Departments of Education and the Military Treatment Facility (MTF), to deliver SBH services to Military youth and Families in specified schools. The purpose of the MOA is to signify the agreement between parties on the general operating principles of the SBH program in the schools involved and a commitment to support the services necessary to ensure that the BH needs of Military Children are being met. The memorandum may include a review of scope of services provided, a general description of the types of collaboration between staff in the two systems, and an overview of the evaluation strategies to be used as presented in this SBH Manual. A legal review of the MOA, by the MTF and the local school district, is required. For planning purposes, finalizing the MOA usually takes between 3 and 6 months. An example MOA is included in the Appendix beginning on pg.47.

Building Awareness of and Involvement in the Program

As the program begins to take shape, expanding relationships and increasing understanding of the program, its mission and services is critically important. To that end, this Manual includes a sample **Information Paper** for Schools, Families, Students and Health/Mental Health Providers (see Appendix, pg. 65). The Information paper should be modified to reflect the SBH program at the local level and distributed to key people in the school community, in the school and around the SBH office. In addition to the information paper, frequent **presentations to school staff** about the program are extremely helpful. The CAF-BHO has a number of sample PowerPoint presentations that can be used by installation staff for these presentations. These mechanisms will help strengthen relationships and assist in identifying staff and family members interested in participating in the school's Advisory Group.

Lessons Learned:

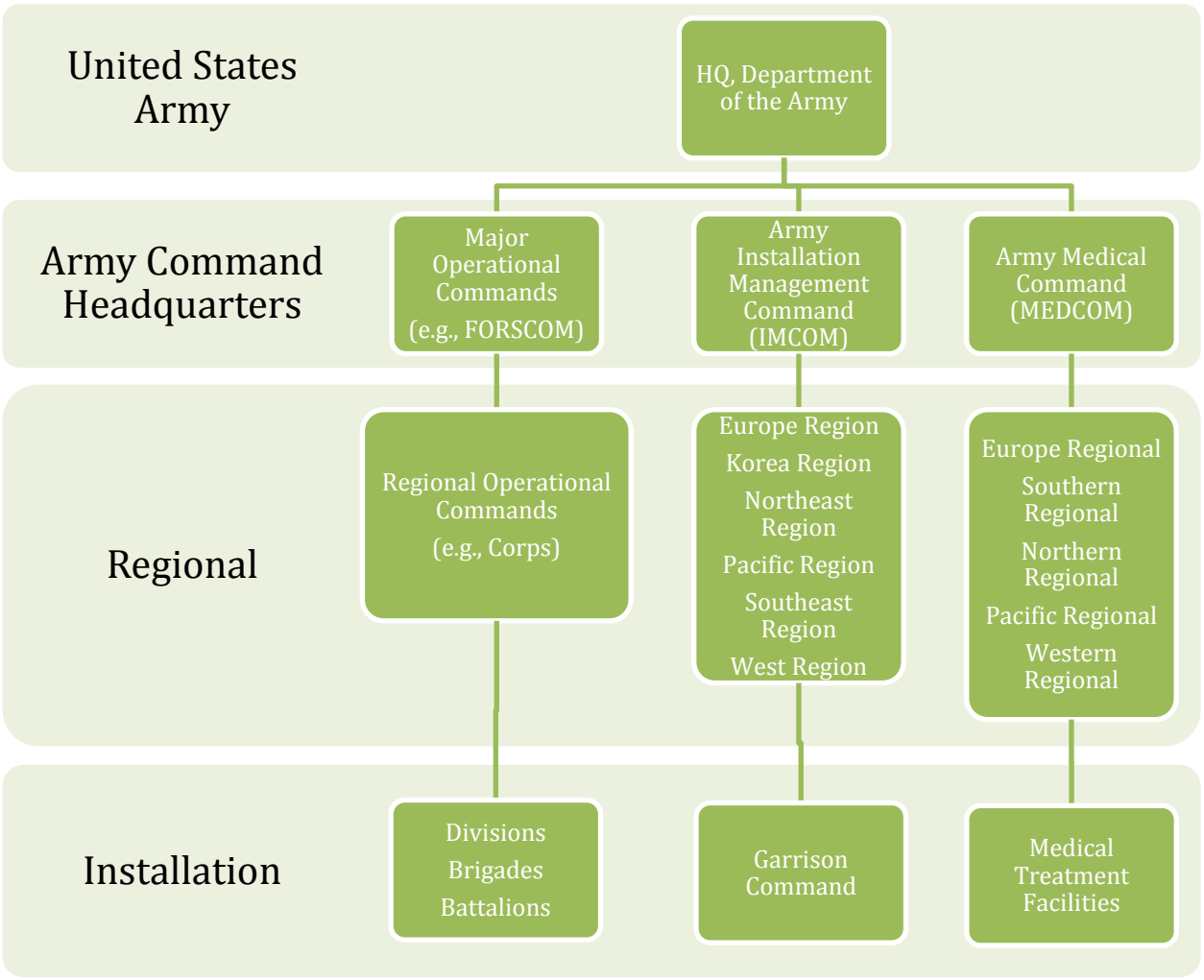
- Relationships, relationships, relationships. To have a successful program, it is necessary to build strong relationships with your installation, schools, and with community partners.
- Seek support of your MTF, Garrison Command and school district leadership early and often.
- It is important to clearly define roles of providers; use flow charts and briefings.
- Assist other clinics in the MTF in understanding your role in the school and the MTF. Develop and share your complementary service.
- Revisit the MOA with staff periodically. Revise your mission and goals on an ongoing basis to ensure you are providing the best level of care to beneficiaries.

IV. HIRING, SUPERVISION AND EXPECTATIONS OF STAFF

Organizational Structures

The CAF-BHO, the primary advocate for SBH programs, falls organizationally under the Army Medical Command (MEDCOM) Headquarters. See organization chart below. Specifically it is located in the BH Division, Health Policy and Services.

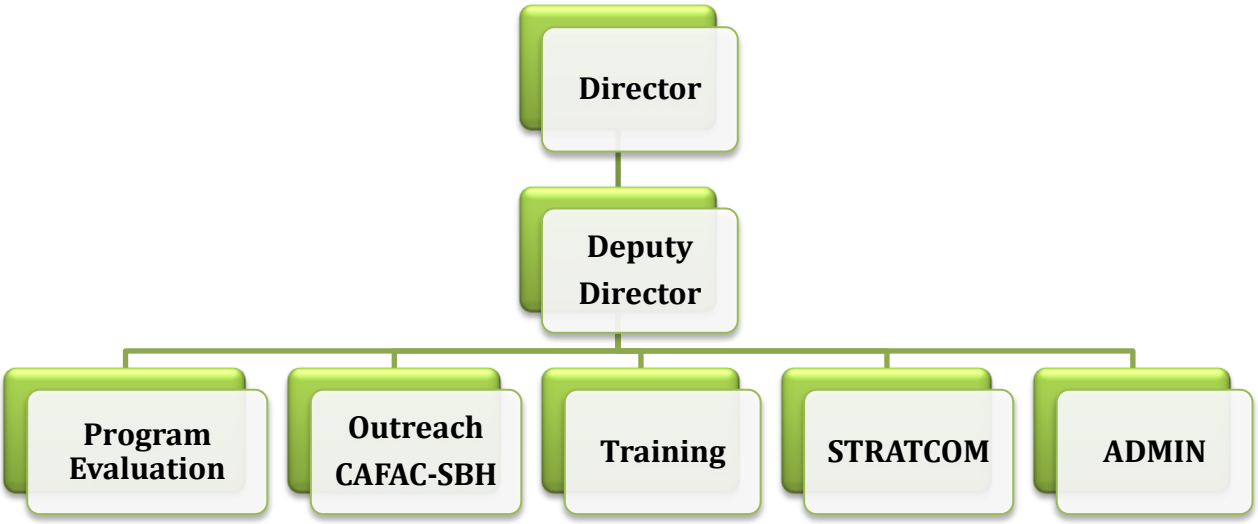
U.S. Army Organization Chart



Program Management

Installation level performance of SBH programs will be monitored by the **Director of SBH**, in consultation with the **Director of Outreach** and **Director of CAF-BHO**. At installations, Site Directors will have full supervisory responsibility over Deputy Directors and Administrative Officers. Directors and/or Deputy Directors will have supervisory responsibility over clinical staff. Performance management systems will adhere to those of the sponsoring MTF. The organizational chart for CAF-BHO is as follows:

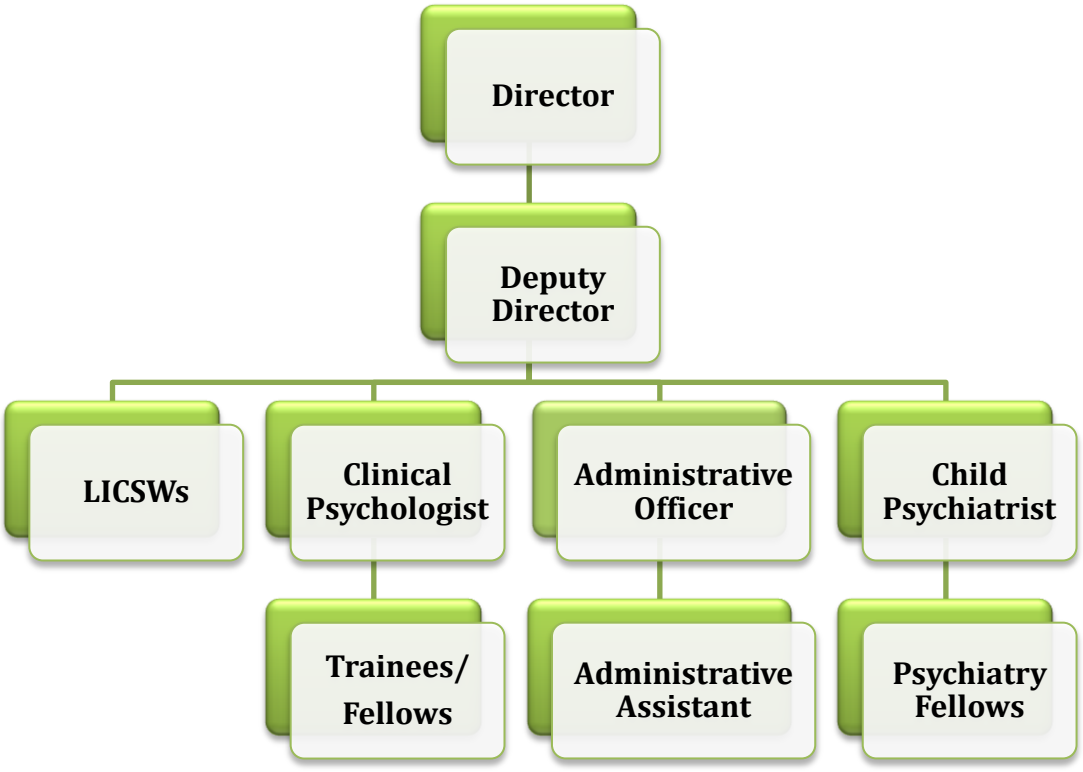
CAF-BHO Organization Chart



Priority in Hiring

The SBH **Site Director** position is critical, representing an experienced leader in child and adolescent behavioral health with demonstrated administrative competence and with a professional reputation engenders the role of champion for SBH in the local community. Logically, the next hire is an **Administrative Officer**, to assist the Director in negotiating bureaucratic and administrative requirements and hiring of other staff. Ideally, the **Deputy Director** would be hired next, representing a licensed doctoral level professional with strengths in implementing evidence-based practices; in providing staff training, and ongoing clinical supervision and coaching for effective practice; and in conducting program evaluation. Clinical staff is hired next. On the next page you will find an example of Installation level SBH Organizational Staffing.

Installation Level SBH Staff Organization Chart



Hiring the Right Clinical Staff

Staff selection procedures should involve multiple team members and should include detailed interviewing, review of credentials, obtaining letters of recommendation, etc., to assure that the best candidates are hired. A number of qualities are associated with successful performance as an SBH clinician. These include:

- Past **experience** in child and adolescent BH and commitment to delivering the best possible services Children and Families
- Personal **integrity and ethics**
- Past **experience** in delivering BH services **in schools**
- Familiarity with **evidence-based practices** especially **cognitive-behavioral therapies** (CBT)
- **Eagerness for ongoing training** and support for effective CBT
- Outstanding **social skills**; for example in developing numerous **interdisciplinary relationships, i**n maintaining appropriate boundaries to assure effective clinical involvement, and in **participating effectively on teams**
- **Ability to work independently** and with relatively little administrative support
- **Ability to handle stress**
- Ability to work effectively with youth, Families and staff from **diverse cultural/ethnic backgrounds**
- Experience in working with broader **systems of care**

Allocating Staff Resources

When allocating staff resources, school attributes such as size, needs, other existing programs and current resources (school system and other community system resources) need to be considered. In all schools there should be clinical staff (commonly social workers and/or psychologists), who work in each school at least two full days per week. Depending on resources, these services will be augmented by clinical services provided by child and adolescent psychiatrists and other psychologists. The primary clinical staff should work full days in schools. **Each school will have one primary clinician designated who will be the SBH leader for that school.**

Expectations for Staff

SBH staff are expected to meet and uphold the following standards:

- Maintain high ethical standards and personal integrity
- Report to work and maintain the work schedule. On full school days, be at the school before the school day starts and to leave after it ends
- Complete all required paperwork and reports in a timely manner
- Stay up to date with continuing education and other learning experiences to maintain current knowledge and professional licensure and credentials
- Adhere to the specific requirements of the sponsoring MTF

Each clinician is strongly encouraged to make contributions to the overall program through a variety of activities. On days when school is not in session, staff are expected to work 8 hours on clearly defined SBH activities, to be approved by the Site Director or Deputy Director. Staff is expected to utilize the time to perform other activities, such as administrative responsibilities, receiving supervision, pursuing continuing education, helping in program development, organizing training activities, assisting in program evaluation, and participating in research and other scholarly activities.

Professional Development

SBH staff are expected to gain continuing education credits as required by their respective disciplines. All sanctioned continuing education activities approved by the Site Director or Deputy Director are considered appropriate use of work hours. Opportunities for professional development include:

- Presentations and/or attendance at local, state or national professional meetings, workshops and conferences
- Seminars offered by other professional or educational organizations
- Attendance at trainings offered by their credentialing MTF
- Preparing materials as part of their role as a content expert in prioritized program areas (described later in more detail in Chapter VII: Program Goals and Action Strategies).

Supervision and Coaching of Staff

All SBH staff members will receive clinical and administrative support, and those who are not licensed will receive clinical supervision according to the mandates of the regulatory body of their respective disciplines, with regard to disciplines, experience and competence of supervisor, number of supervision hours, and type of supervision required. Supervisors will be designated by the Site Directors or Deputy Directors, should emphasize evidence-based practices, and should have experience in SBH or with the populations served within the schools. Supervisors are on-call to the designated supervisee in case of clinical emergency. **Ongoing professional support**

will be provided to all staff, including licensed staff to help assure effective implementation of evidence-based practices (reviewed more intensively later in Chapter VII: Program Goals and Action Strategies).

Site Visits and Staff Evaluations

Yearly, the Director of SBH for CAF-BHO (or his/her representative), will conduct a site visit at each installation, and will meet with the Site Director, Deputy Director, Administrative Officers, and Clinical staff to review operations and observe team processes. This person will also meet with the Superintendent or designated lead for the Advisory Council, and with school principals in schools where SBH is implemented. Following these visits, an after action report will be developed and shared with the Site Director, Advisory Council leads, and the CAF-BHO Advisory Board. Based on findings from these site visits, the Director of CAF-BHO, with guidance from the Advisory Board, will then work with the Director of SBH on plans to provide continued support and improve services at each installation.

At the installation level, Site Directors and Deputy Directors will be responsible for ongoing staff evaluation with formal written evaluation at least yearly. Clinical staff will be evaluated based on the following criteria:

- Chart review to include completion of assessment packet, interview, appropriate diagnosis and treatment plan
- Quality of clinical work
- Clinical productivity
- Utilization of relevant school resources
- Utilization of relevant Army and community resources
- School principal's evaluation of the clinician (e.g., based on attendance, reliability, availability, responsiveness to student needs and ability to build and maintain positive relationships in the school setting)
- Administrative activities (e.g., attendance at meetings, completion of required paperwork)
- Meeting clinical and administrative requirements of MTF

Program Meetings

Program meetings should be held once per week and year round. The day and time are to be determined by the Site Director. Meetings should include discussion of administrative and clinical issues, case discussions, and include regular and active training on implementing evidence-based practices. Optional meetings may be held at any other times for purposes of continuing education or as needed. Staff are expected to attend all program meetings. Any conflicts should be discussed with the Site Director or Deputy Director.

Absences

Absences from work (TDY, vacation, personal, or sick leave) must be approved and documented appropriately on time sheets. Staff are expected to try to match their personal vacation time with the school calendar as much as possible; that is to make every effort to take longer vacations at times when school is out of session.

Exit from School Assignment

When clinicians move to a new school or are leaving the program, all active cases should be closed or transferred, and all paperwork for cases should be completed to specifications of the MTF.

Involvement of Trainees

There can be mutual benefit to the SBH program and to trainees for externship and practicum arrangements between local colleges/universities offering a graduate behavioral health degree (e.g., in psychology, counseling, social work) and the MTF. Trainees should receive strong on-site supervision consistent with requirements of their graduate program and the policies of the MTF. Site Directors should provide some accommodation to the clinical demands for staff supervising trainees, as this can represent a notable work demand. Trainees are expected to adhere to the accountability standards for regular SBH staff.

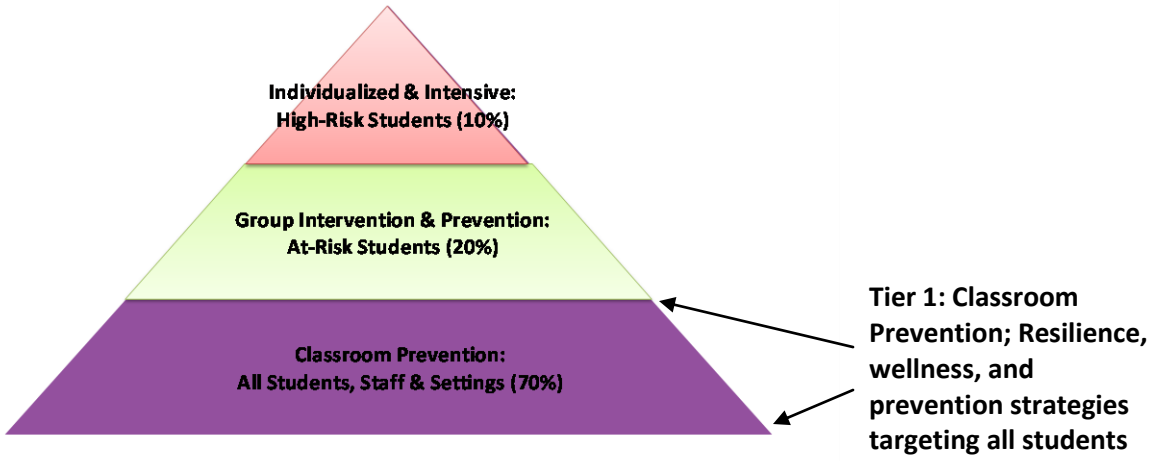
Lessons Learned:

- The government hiring process can take a great deal of time and can often be frustrating. It is important to stay on top of the processing of candidates through the system to ensure it is moving forward.
- Working as a provider within the schools can be challenging; Military Children have a different lifestyle than that of their civilian counterparts. Thus, hiring providers who are knowledgeable of the unique challenges of Military Families, who have strong clinically and are flexible "self-starters" is KEY.
- It is important to underscore that a confidential, devoted clinical space is essential for SBH providers in the school to ensure the confidentiality and privacy of a child or parent who is working with the provider. This may seem obvious, but schools often expect an "open door" policy environment with staff.
- Get creative with continuing education. Share trainings with other departments in the MTF and with the school district.
- Acquiring trainees for your program can be a long process. Begin by identifying what your program can offer trainees (clinical experience that will be provided, supervision structure, continued educational experiences) and dialogue with community partners early and often.

V. PROGRAM SERVICES

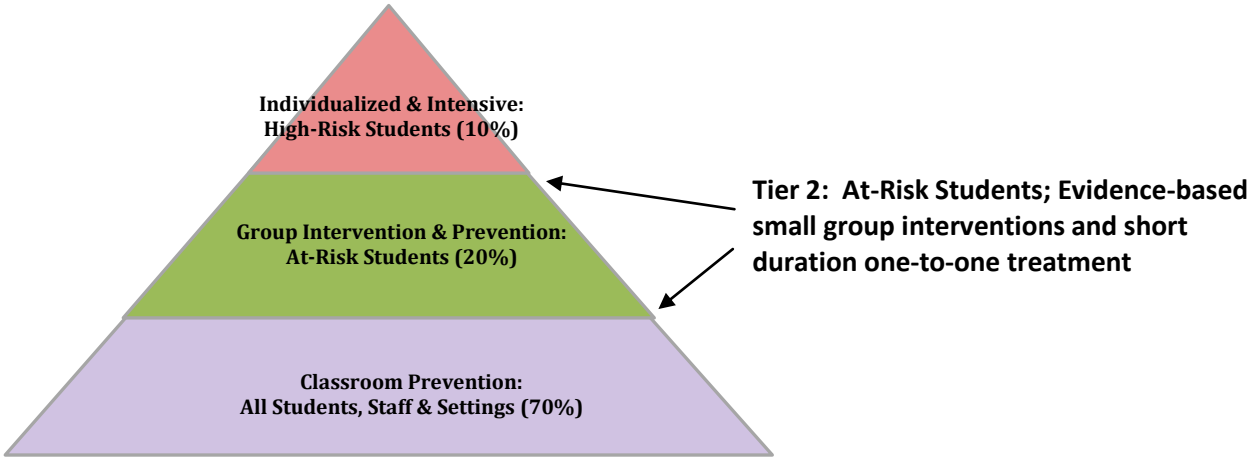
Three-Tiered Approach to SBH

Program services should reflect a three-tiered approach as presented below.

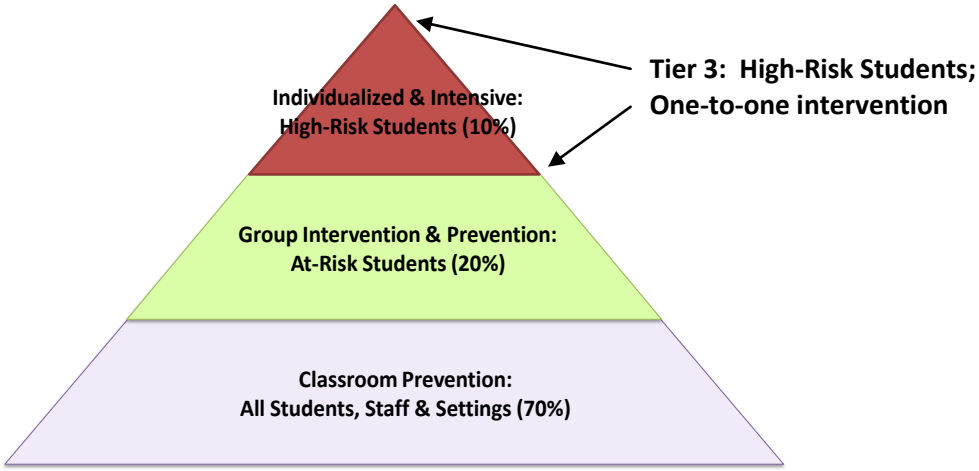


Tier 1 services involve helping to improve the **school environment**; for example, assuring that all places within schools are safe, reducing student bullying, taking actions to promote positive and nurturing interactions among students and staff, and implementing **systems of Positive Behavior Intervention and Support (PBIS)**.

Ideally, the school is implementing PBIS as supported by most states and local school districts in the U.S. Since there is very strong compliment between PBIS and SBH, it is appropriate for SBH leaders to pursue PBIS connections for the schools, and for SBH clinicians to help support its implementation. Please note that PBIS is a social/behavioral strategy for **Response to Intervention** (a dominant theme within the current U.S. educational system focused on tailoring interventions to student needs based on evaluation of progressively implemented interventions), with **major emphasis on a multi-level prevention system, systematic screening of youth for early problems, active progress monitoring, and data-based decision making**. This has been shown to be more effective than a static testing approach. Tier 1 services are meant to be helpful to all students. For Military schools developing **programs to ameliorate deployment-related stress are of the highest importance,** and the CAF-BHO will assist installations in selecting and implementing these programs.



Tier 2 services are focused on **students showing early signs of behavioral problems or demonstrating signs and symptoms of risk**, and could be applicable to all students given a major negative event affecting the whole school such as large scale deployments or the death of Soldiers. Tier 2 services include **focused assessment and intervention services** (e.g., for up to a few session), implementing **supportive and evidence-based group interventions,** and **working collaboratively with educators in promoting positive behavior** and managing negative behavior.



Tier 3 services provide BH **treatment for students and their families presenting more serious emotional/behavioral challenges**. SBH staff offer more intensive assessment and diagnostic evaluation, and treatment. This may include individual, group and/or family therapy with close case management.

In general, SBH staff should emphasize Tier 3 and Tier 2 services targeted to Military Families with adherence to procedures that meet accreditation requirements of the MTF. However, SBH staff may provide consultation services to school staff, focused on general issues or strategies to assist students and promote behavioral health for all students. SBH staff should also be available to assist students and Families in connecting with other services. For example, for **non-military Families** this would include services offered within the school, and through the local community behavioral health agency. For Military students and Families, this would include services offered through Child Development Centers, Child and Family Assistance Centers, and through Army Community Services. In addition, SBH staff represent a resource for school staff; for example, in providing guidance on coping with stresses of Military life, promoting the use of wellness strategies, etc.

SBH programs should utilize evidence-based curriculum and practices in the direct services being provided to students and Families in all three tiers of the prevention/intervention model illustrated above. To learn more about evidence-based practices, please visit the Substance Abuse and Mental Health Services Administrations (SAMHSA's) National Registry of Evidence-based Programs and Practices (NREPP). This helpful website is an online registry of reviewed behavioral health and substance abuse interventions that have been determined to have quality research supporting the intervention and can be readily disseminated. The registry can be found at http://nrepp.samhsa.gov/. The CAF-BHO will be providing training to installations in modularized CBT interventions.

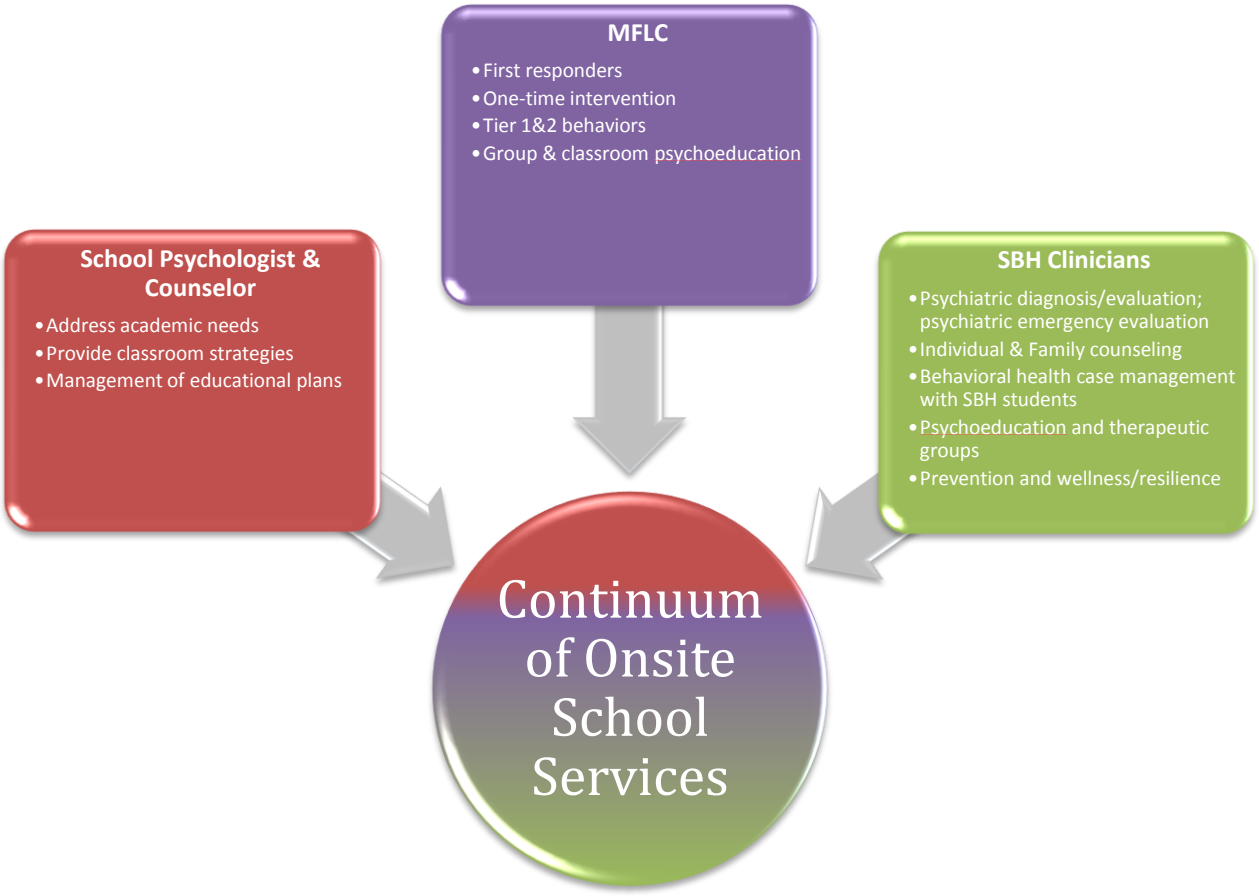
Examples of Prevention and Wellness Groups:

- Classroom Based Deployment Group (coping with deployment and reintegration)
- Buddy lunches and Brigade Basketball – positive mentoring of students from the Soldiers from an adoptive brigade.
- Understanding and Combating Bullies
- Common Sense Parenting; 1-2-3 Magic; SOS Help for Parents
- "Copier Chats" – posting info for teachers around the copiers and quick chats about symptoms of disorders or common challenges for Military children.
- Brown Bag series – symptom and intervention specific support
- "Ask a Doc" coffee hours
- Health and Fitness groups; Crafting Club; Child-Parent playtime
- Campaign of Kindness – Filling someone else's bucket today (how can you give to others in your day and make a positive contribution)

Triage Team

The SBH team and school will need to establish a **Triage Team** to discuss students referred for evaluation and treatment of behavioral health issues. The team should be chaired by either the SBH clinician assigned to the school or by a SBH professional, such as the school psychologist, counselor, or social worker. The Triage Team should meet weekly to discuss the referred students, progress being made, changes in treatment plans, and other BH issues pertinent to the school. A lay component of the Triage Team is **monitoring outcomes and ensuring ongoing performance improvement.** The Triage Team will work with other teams in the school (e.g., PBIS, Student Support and School Advisory Team) and will also assess and monitor staff, family and student relations, and issues related to community and Military life.

How SBH Providers Fit



Interdisciplinary Collaboration and Role Clarity

SBH is inherently interdisciplinary and **SBH staff should cultivate and expand a range of interdisciplinary relationships**, including school-employed behavioral health and health staff, educators, school administrators, family leaders, Military Family Life Consultants (MFLCs), and School Liaison Officers (SLOs). Often these same staff will serve on the School Advisory Council, increasing collaborative opportunities. However, SBH staff should be aware of the tendency at times toward **mission drift**, as school leaders, school-employed behavioral health staff and educators will often try to pull talented people into discrete or ongoing projects. Staff should display a spirit of eagerness in collaboration but also assertiveness to not enter roles that will compromise their ability to provide effective Tier 3 and Tier 2 services to Military students and their Families. As mentioned earlier, it is also critical that SBH **not be viewed as in any way replacing** other behavioral or behavioral services for students in the school, but instead should be viewed as **augmentive.** In fact, it is highly recommended for utmost effectiveness, that SBH services collaborate very closely with other Military school-based services including MFLCs and SLOs, as well as the other school-based support providers.

Lessons Learned:

- While building a presence and relationships within the school, SBH staff often become involved in school activities/committees that aren't directly associated with clinical care (e.g. playground duty; coordinating donations around the holidays; planning school events); this can be challenging to pull back as the clinician's client roster begins to fill up. It is important to maintain as much balance as possible in terms of active involvement while simultaneously *monitoring and planning* for the challenges this creates.
- Get early participation of the Principal and other key stakeholders in the Triage Team meeting. This ensures investment and team collaboration.
- Understand the resources that are available in the school and school district (e.g., SPED; MFLC, etc.). Triage is an excellent venue to discuss if SBH is the best fit, or if the child could be better served with a different resource in the school (e.g. a small deployment group with the MFLC)

VI. CLINICAL SERVICE POLICIES AND PRACTICES

Confidentiality

Confidentiality must be respected and maintained at all times. The limitations of confidentiality in accordance with relevant federal and state regulations (danger to self, others or endangerment due to abuse or neglect) should be clearly stated at the initial meeting with the student and family. Information regarding a student may only be shared with the permission of the legal guardian and should include the assent of the student. Prior to sharing information with another agency, a written release of information must be obtained from the legal guardian for that specific purpose (see Appendix pg. 68). Prior to sharing information with school staff the student's assent and legal guardian's consent must also be obtained. When obtaining assent from the student, the clinician should consider the student's developmental level and cognitive abilities. The information that is to be shared must be germane to the presenting issue.

Adhering to HIPAA and FERPA

As a health service operating in schools, SBH operates under both the Health Insurance Portability Accountability Act of 1996 (HIPAA) and the Federal Rights to Privacy Act of 1974 (FERPA). Both federal laws require information regarding a student or family be treated with confidentiality and ensure appropriate protection of the student/patient and family privacy rights. A major goal of HIPAA is to assure that the individual's health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. FERPA similarly gives parents certain rights with respect to their Children's education records. The parental rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level, i.e., eligible student. Generally, schools must have written permission from the parent or eligible student in order to release any information to a third party. Under certain specific conditions FERPA allows a school to disclose education records without consent (34 CFR Section 99.31). In the SBH program, HIPAA and FERPA should not be regarded as competing regulations. The common goal of both federal privacy laws is to assure that information, health or education, about the individual is treated with confidentiality.

Consent

In accordance with federal and most state regulations consent must be obtained from the child's parent or legal guardian for students aged 17 and younger prior to receiving BH services. Depending on State of residence, there may be provision for minor consent, and in this case, these State provisions should be followed. Written consent is required for all students (see Appendix pg. 69). In emergency situations, such as severe injury or death of a Soldier Family Member, potential for dangerousness to self and/or others, and child protective services involvement, it is acceptable and appropriate for a clinician to intervene, regardless of whether consent has been obtained. However, even in these circumstances consent for services from the parent and/or guardians should be sought as soon as is feasible.

As in any traditional BH clinic setting, a specialized consent to treat minors with psychotropic medication and other psychiatric medications is also required. Verify your local MTF BH clinic and hospital policies and regulations regarding consent requirements to treat a minor with psychiatric medications. In addition, it will be important to provide ongoing medication education to both the student and the guardian. These consents,

documentation of medication education, and patient/guardian response must be documented in AHLTA, in accordance with Joint Commission standards. We have provided an example of a generic Psychotropic Medication Consent form (see Appendix pg. 70), but any specialized consent that has been approved by the local MTF JAG office, can be utilized for this purpose.

Consent for Release of Information

A Consent for Release of Information form (see Appendix pg. 71) must be signed by the student's parent or legal guardian if the clinician wishes to obtain or share clinical information with any other source or provider, including staff in the school. Blanket releases of information should be avoided, and even when there is a release of information, clinicians should release only information relevant to the question at hand. The Site Director or Deputy Director should be consulted whenever there is a question about the appropriateness of a particular request for information on a student or family receiving SBH services.

Crisis Planning

At each site, crisis plans should be developed early in program development (e.g., on how to address child abuse and neglect reporting, psychiatric hospitalization, suicidal/homicidal ideation and behavior). Individual programs should also develop plans for rare events such as the death of a provider or patient, and for handling ethical complaints against providers.

Importantly, at each site, and with broad stakeholder input (e.g., Army, Families, school) plans should be established and continually improved for **SBH response to catastrophic events involving Military Personnel** (e.g., multiple casualty incidents in theater or on base, deaths of Soldiers). Across program sites there should be ongoing dialogue on strategies that are working well and not working well, toward continuous improvement of approaches to effectively respond to these catastrophic events. SBH staff should learn about and make connections to the school's Crisis Response Team and assure that any response to a crisis is coordinated with and does not duplicate the efforts of this team.

In many cases, SBH staff **may not represent the first line of response**, and situations such as intervening on physically aggressive behavior of students should be avoided, unless there are no other means urgently available for such intervention. SBH providers should be aware of the MTF's policies on high risk involvements with patients.

Referral and Intake Processes

Referrals for service are received from any party concerned with students' welfare, including health professionals, BH professionals, educators, school administrators, parents and family members, social service agencies, other students, and by students themselves. All referral sources and information are confidential, unless otherwise arranged with the referral source. For the purpose of this discussion, these referrals will be classified as those that **originate through the school** (e.g. principal, teacher, parent who approaches school staff) and those that **originate outside of school** (e.g. MTF, consult from another clinic/provider, parent contacting SBH office directly.

School Referrals

When school staff (including counselors, teachers, or principal) or parents are concerned about a student and believes he/she would benefit from SBH services, they would complete a Concern Referral Form (see Appendix pg. 66 &67) and submit to the school counselor or principal. A **Consent for Release of Information** (see Appendix pg. 69 & 71) giving the Triage Team permission to discuss the student's issues and needs must

also be completed. Many schools have a multidisciplinary student intervention team in place to address the academic and emotional/BH needs for students. The SBH screening forms, from both parent and teachers, are then discussed with the student intervention team to determine if the school has addressed the student's academic needs and what the best level of support may be (meeting with a school counselor, MFLC or SBH provider). When determined that SBH is the most suitable/best fit for the student, the Triage Team discusses the student's case and an intake packet is distributed to the family. When the SBH intake packet is returned to the school, the SBH provider contacts the family to schedule an intake.

External Referrals

SBH can also receive referrals from another provider within the MTF, a parent calling the SBH offices directly or another SBH program (e.g. when a family has a Permanent Change of Station – PSC).

When a child is referred by another provider, the SBH service will contact the provider to discuss the concerns and conduct a screening to determine if SBH is the best resource for the child/family. When determine that SBH is the most suitable/best fit for the child, an intake packet is distributed to the family. When the SBH intake packet is returned to the school or SBH office, the SBH provider contacts the family to schedule an intake.

When another SBH program refers a child for services, the receiving SBH office coordinates care for the child with the referring SBH program. Often the family does not yet know which school their child will attend upon arrival so it is important that all parties remain connected during their transition. Although much information regarding the child's BH history and treatment can be gleaned from the referring SBH provider, the receiving SBH provider should schedule an intake to become acquainted with the family and determine the family and child's concerns and therapeutic goals.

Intake Process

Urgency of referral is determined within Triage Team or Program meetings or in other cases, in consultation with Site Directors or Deputy Directors. All students and legal guardians provide pertinent information to complete the Intake Assessment (see Appendix pg. 72). General background, guardian background, child and family medical and psychiatric history, developmental history, behavioral and emotional history, academic and social history, mental status, clinical presentation, and student's perceptions and strengths are recorded. Based on the interview and diagnosis, the treatment recommendations are completed. Intake documentation should be complete by at least the end of the 4th counseling session, along with a documented review with the student and guardian.

Documentation Guidelines

Documentation of all clinical contacts should occur as soon as possible, but in all cases, within 72 hours. Content of documentation is dependent on the nature of the therapeutic contact but should include specific information consistent with Joint Commission and professional guidelines (e.g., treatment plan, client response to intervention, etc.). Clinical records should be entered into the child and/or parent's electronic medical chart (AHLTA). Formal documentation per MTF policy and military regulation should occur for all mental health treatment services, including assessment; and individual, family, and group therapy sessions. When SBH staff are providing a more preventive service (e.g., skills training group) with a school-employed behavioral health staff member, then more informal forms of consent are allowable (e.g., permission slips), and there are no formal documentation requirements for these more informal services. Contact your SBH Administrator or MTF Judge Advocate General's (JAG) office for questions regarding local policy, regulations, and procedures for electronic, paper, and BH specific documentation.

Maintenance of Records

Clinical records will be maintained on the electronic medical chart, AHLTA. Any hardcopy records (e.g., test protocols, patient produced information) may be maintained on a convenience chart to be kept in locked file cabinets per Joint Commission standards.

Closing/Transferring Cases

A case closure/transfer summary should be completed and retained in the student's chart when a case is either closed or transferred after four or more sessions. If transferring to another SBH clinician, the receiving clinician should be provided a copy of the summary along with the clinical chart. A student's closure or transfer plan should also be discussed with the school's Triage Team. Each site should develop a listing of relevant school, Army and community resources to share with students and Families when cases are closed. Closure and transfer of cases should adhere to policies of the MTF and Joint Commission standards.

Installation to installation transfers may occur from one SBH program to another (e.g., from the SBH program at Joint Base Lewis McChord to the SBH program in Vilseck, Germany). In the event that the SBH provider or school staff receives information that a student who is currently receiving SBH services will be transferring to another school which has a similar SBH program, the general procedures suggested below should be followed as closely as possible:

1. Develop a transfer plan with the current school's Triage Team and parent or legal guardian.
2. Obtain written consent from the parent or legal guardian to share the transfer plan and other relevant student information with the Director or Assistant Director of the receiving SBH program.
3. Send the transfer plan and other relevant student information for which parent or legal guardian consent has been obtained to the receiving SBH Director or Assistant Director.
4. Give the parent or legal guardian a copy of the documents as well as additional contact information (phone, email) to ensure as smooth of a transition as possible.

Exceptional Family Member Program (EFMP) BH Considerations

SBH programs are a primary entry portal into the EFMP program for Military Children and Family Members with special needs. EFMP enrollment provides a summary of a family member's medical or educational needs beyond the basic level of services provided by most schools and/or MTFs. Similar to seeking professional help for BH disorders, the EFMP enrollment process has been associated with stigma and service-member's fear of its impact on their career. It is important to understand that enrollment in EFMP does not adversely affect a service-member's selection for promotion or training, and information concerning EFMP enrollment is not available to Military promotion boards. Enrollment summaries simply allow Military assignment managers at Army personnel agencies to consider documented medical and special education needs of exceptional family members in the service-member's assignment process. Enrollment into the EFMP program is mandatory and profiles must be updated when changes occur or every three years, at a minimum.

Although the responsibility of enrollment is that of the service-member, Families are often not familiar with the process or even recognize that they have a family member who qualifies for special needs identification. Per AR 608-75, a family member with any physical, emotional, developmental, or intellectual disorder that requires special treatment, therapy, education, training, or counseling is considered an exceptional family member (EFM). Any diagnosis requiring psychopharmacology management, 504, IEP, or special school accommodations,

likely meets enrollment criteria. Any diagnosing or specialty care physician can initiate or provide revisions in the EFMP process. School district psychology and/or special education staff should be consulted in completing 504 and IEP documentation. Criteria for enrollment in EFMP can be found in AR 608-75, Appendix B. http://www.apd.army.mil/pdffiles/r608_75.pdf

In April 2011, a revised format of form DD 2792, Exceptional Family Member Program Medical Summary, and DD 2792-1, Exceptional Family Member Program Special Education/ Early Intervention Summary were released including separate addendums for BH diagnosis needs (2792 Addendum 2) and Autism Spectrum Disorders and Significant Developmental Delays (2792 Addendum 3). Fillable forms are available at: http://www.dtic.mil/whs/directives/infomgt/forms/index.htm. After completion of the form/s, and making at least one copy, the service-member will deliver the form/s to the local MTF EFMP or Special Needs Programs Office for processing. SBH staff should consult with the MTF EFMP office for questions and local procedures. Any SBH client with an existing diagnosis, diagnosed within the SBH program, or requiring 504 or IEP services, should be screened for enrollment consideration. Advocacy and communication skills are essential for these Families, and should be considered in educational opportunities.

Joint Commission Accreditation

SBH programs are subject to inspection and the accreditation process from the Joint Commission (TJC), formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Commission develops performance standards that address crucial elements of operation, such as patient care, medication safety, infection control and consumer rights. Most state governments require that healthcare organizations, and their affiliated services, be accredited by the Commission as a condition for licensing and reimbursement claims.

SBH programs serving Military populations are the responsibility of the associated MTF, where the SBH providers are credentialed. Although the SBH program itself may be located off-site of the MTF or within a civilian owned facility, the responsibility for any medical or BH care provided within, is the responsibility of the credentialing facility.

At the time of publication, there were no specific guidelines or publications from TJC specifically addressing SBH programs. The SBH programs that have previously been inspected and completed the accreditation process, have utilized a combination of BH, Hospital, and Ambulatory Care performance standards, pertinent to SBH services, as outlined by TJC. Check with your MTF Risk Management Division to gain access to online TJC tools, obtain performance standards, or for further questions. http://www.jointcommission.org/

Lessons Learned:

- REMEMBER that the school system and MTFs are governed by different rules regarding the sharing of information (FERPA versus HIPAA). Providers should be prepared to limit information shared during a triage meeting or other discussions with school staff without specific permission from guardians. This can be frustrating for school staff and the responsibility falls with SBH to discuss this in a supportive and understanding (yet firm) manner.
- Ensure that school staff understands that sessions with the SBH provider are private and that the school staff should not discuss that they saw a family or child walk in/out of a session. Additionally, school staff should be informed to not interrupt a session unless there is an emergency.
- Have a clear crisis plan and understand the process for evaluating/admitting a child who is a threat to self or others. This can be a tricky process when providing services outside of the MTF. In addition, consult school crisis response policies for additional guidance.
- Difficulties with internet/wireless connectivity can be a challenging hurdle to completing charting in the specified timeframe. Address IT issues early with both the MTF and school district. Involve leadership in the discussion to ensure a timely solution. In some cases, technology "workarounds" will be necessary.
- Engage with the MTF Risk Management Division early in the SBH initiation and planning phase to insure that physical space is adequate and compliant with Joint Commission requirements.

VII. PROGRAM GOALS AND ACTION STRATEGIES

Overarching Goal

The overall goal of the initiative is *to facilitate access to care by embedding BH within the school setting, and to provide state of the art prevention, evaluation, intervention, and treatment through standardization of SBH services and programs*.

In addition, specific goals related to a full array of effective programs and services, reflecting a three-tiered model will be implemented at the Installations. These goals and the action strategies to achieve them are as follow:

Goal 1: To enhance the school climate and broadly promote mental health, wellness, and school success for students, Families and school staff

a) Conduct ongoing needs assessments involving meetings and/or focus groups with all key stakeholders: students, teachers, other school staff, family members, health and BH staff, and Military leadership. In recent years, these needs assessments have revealed a number of on-going stressors being confronted by Military Families relating to:

- Deployment cycles
- Traumatic loss
- High levels of family conflict and disruption
- Separation of parents and Children for long periods of time
- Marital infidelity and divorce
- High levels of conflict among and between different groups (e.g., school staff, Families, staff from other child serving systems)
- Financial status and need

Ongoing needs assessments should consider student, family and school staff functioning in relation to the ARFORGEN and school cycles, and their interactions (e.g., a major troop deployment right at the beginning of the school year). There are a number of resources that provide valuable guidance to Military Families on the ARFORGEN cycle, including the New Emotional Cycles of Deployment (U.S. Department of Defense, 2006), which identifies 7 adjustment periods: 1) Anticipation of Deployment, 2) Detachment and Withdrawal, 3) Emotional Disorganization, 4) Recovery and Stability, 5) Anticipation of Return, 6) Return: Adjustment and Renegotiation, and 7) Reintegration and Stabilization. A major task *and opportunity* for SBH is to help Families to develop and implement effective programming to assist them in coping with ARFORGEN related stresses and milestones (*see ARFORGEN diagram page 32)*.

Related to program resources, some of these meetings will be more formal, as in focus groups; while other meetings will be informal. Notes from these meetings will be maintained, and will be organized for discussion during Triage Teams meetings, and Advisory Group and Advisory Council meetings.

Army Force Generation Cycle (ARFORGEN)

The Army's operational rotational model in which groups of Soldiers predictably cycle; reset, train/ready, and available. Military family programs align and coordinate resources and services with the cycle to Provide support to Children and Families during the time of greatest need.

b) Nurture relationships among Army staff, school staff, and Military Families through structured (e.g., focus groups) and unstructured forums (e.g., coffee hours).

Structured activities as a follow-up to needs assessments will help to build relationships among Families, school and Army staff. In addition, SBH staff should be available to Families and school staff more informally; for example, through coffee hour discussions, participating in school events, and having open times for non-therapy related discussions.

c) Systematically seek to reduce stigma of accessing BH services through staff training and BH promotions.

A critical component of climate enhancement is a systematic approach to reduce the stigma pertaining to emotional and behavioral problems of students and Military Families, and seeking services for these problems. Clinical staff should convey and model that BH issues are universal (e.g., under extreme stress all people demonstrate some problems in coping), and that seeking help for these issues is a sign of strength. SBH staff should also organize formal presentations for school staff and collaborating community staff conveying these messages and ideally include school, Military and community leaders who are open about their own struggles

with BH challenges. SBH leaders should be in active collaboration with Military leaders to get messages out on the appropriateness, importance and benefits of seeking help for BH issues, including seeking help for themselves and their Children through programs in the schools.

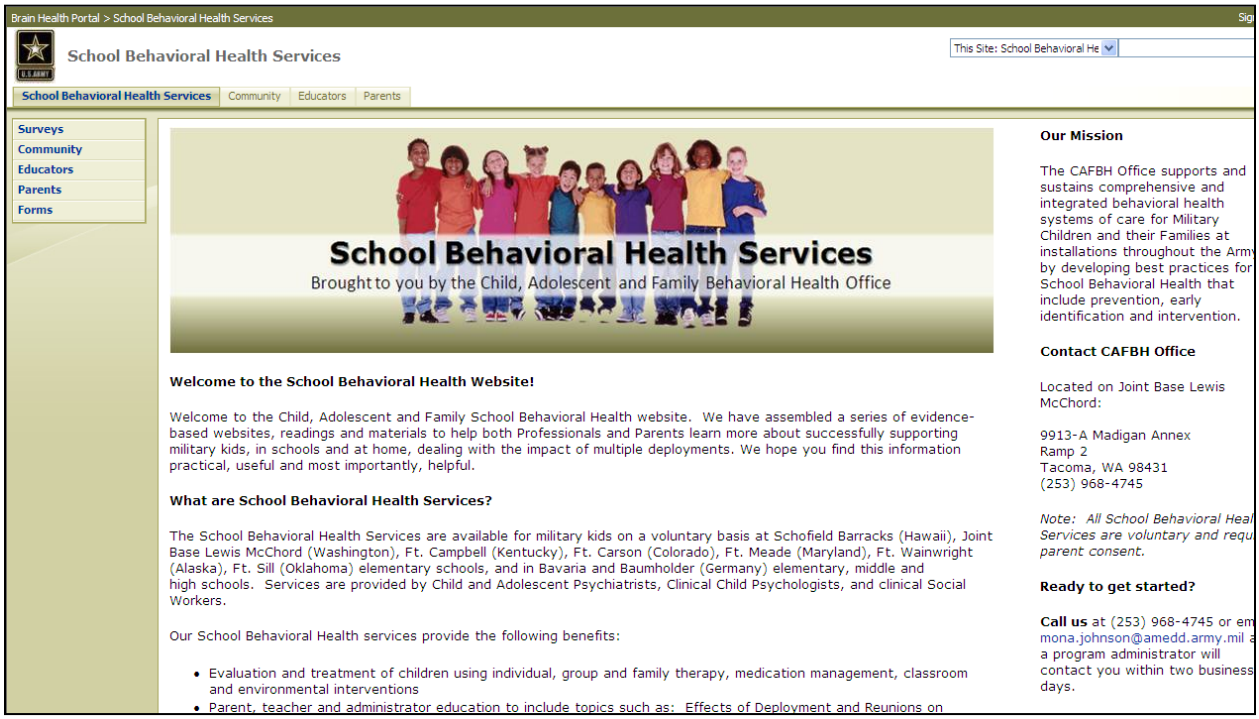
d) Develop a comprehensive directory of relevant school and community resources for students, school staff and Military Families.

At all sites, teams should seek to understand existing programs and services in the school through a formal resource mapping process that ensures collaboration with and utilization of relevant programs and resources in the school, in avoiding duplication in services. One of the SBH providers should be assigned to develop this resource directory that includes school, Military and community resources available to staff in the schools. In this work, there should be outreach and connection to resources of the local child serving systems, Army installation, schools, and other community agencies. Directories should include relevant health, BH, educational, recreational, and youth development programs and resources for students, as well as relevant resources for parents, such as employment related services. Directories should be updated yearly.

Goal 2: To deliver a range of health promoting and preventive interventions, including those focusing on major themes of resilience, wellness and effective coping with stress for Military Families and schools staff

A broad array of health promotion and prevention services should be pursued in the schools. Three particular areas will be emphasized: Resilience, Wellness, and Effective Coping with Stress. The frequency and form of training will be determined by each school's needs and related to the ARFORGEN cycle.

To assist SBH Clinicians and Educators in finding additional resources and materials to meet the educational intent of this goal, CAF-BHO has assembled a comprehensive SBH specific website, located at http://brainhealth.army.mil/SBH, which contains resources and materials designed for both professionals and parents to learn more about how to successfully support Military Children and Adolescents.



Goal 3: To deliver a range of effective interventions to Military Families addressing emotional and behavioral concerns and the unique stressors of Military life

a) Train school staff to effectively identify and refer students for SBH services.

SBH providers will provide training to school staff on emotional and behavioral problems in Children and adolescents, signs and symptoms of problems, and mechanism of referring students for help. SBH staff will also regularly participate in grade level meetings with teachers to develop relationships with them and to promote awareness of services. In addition to promoting utilization of SBH, staff should direct school staff to other supportive resources and programs in the school, available through the Army and in the community.

In addition, Triage Teams will actively engage in surveillance for students who may need BH services. This will include looking for concerning patterns in grades, attendance, lateness and discipline referrals, as well as a pattern and frequency of interactions with other services such as with the school nurse.

b) Emphasize training, ongoing coaching and support for SBH staff to implement the most effective evidence-based preventions for disorders of Depression, Anxiety, Disruptive Behaviors, ADHD, and Trauma.

For each disorder, the top 3-5 evidence-based skills will be identified, and training and support will be targeted to these skill areas. Given that there is some overlap in skills across some of the disorders (e.g., Depression and Anxiety; Disruptive Behavioral Disorders and ADHD), 15 skill areas will be targeted for intensive training and ongoing implementation support. Key intervention strategies for each disorder are reviewed below, and additional tip sheets for providing training and ongoing support for implementing skill training for each disorder can be found on the University of Maryland Center for School Mental Health website at www.schoolmentalhealth.org

c) Have individual staff assume particular areas of expertise to attain deeper knowledge and serve as a resource to other staff (e.g., 6 full time staff each take on at least one of the following realms –Internalizing Disorders, Externalizing Disorders, Trauma, Resilience, Wellness, and Effective Coping).

Given the breadth and depth of knowledge demands in relation to prioritized themes (Resilience, Wellness, and Effective Coping), and modular cognitive-behavioral interventions, all staff will be expected to have a good knowledge base in each of these areas. In addition, Practice Area Leaders (PALs) will be identified for each of the three critical themes, and for Internalizing Behavior Disorders (Depression and Anxiety), Externalizing Disorders (Disruptive Behavioral Disorders and ADHD), and Trauma-Related. While not expected to become "experts," with guidance from CAF-BHO, PALs will organize and share resources related to their content area, and help to organize and conduct relevant training, with close involvement of Director's and Deputy Directors. PALs with content area expertise across installations will work together to share information, promoting cross-installation collaboration, and increase the range and depth of relevant resources used at each installation.

d) Ensure a strong and ongoing engagement and empowerment of Military Students and Families.

The SBH program will use research-based strategies to ensure the most effective approach is taken in interactions with Military Families and students. For example, first interview engagement strategies will be used (McKay, 2004), in which the provider and family members have an open dialogue about past service experiences, discuss concerns, plan for initial meetings, and discuss strategies to overcome likely obstacles. In addition, proven strategies will be employed to ensure providers are flexible and creative, take time to assess specific needs of Families and provide resources that address those specific needs, use active and multiple

methods of communication, and use reminders as indicated between sessions (Lowie et al., 2003). Efforts with Families will follow the framework of Hoagwood (2005), involving four key domains:

- *Engagement*: Forming a connection with Families from the first point of contact. Clinicians meet Families "where they are," enhance the relationship, and maintain strong connections throughout.
- *Collaboration*: Actively partnering with Families in the assessment and intervention. Clinicians turn to Families for insight and knowledge tailoring the therapeutic processes to issues at home and in the community.
- *Support*: Serving as a positive source of resources and support to Families, and helping them make connections to viable supports in the school and community.
- *Empowerment*: Promoting family involvement at the highest level. Clinicians reduce perceived barriers, equip Families with the means to contribute to and guide the treatment process, and help to instill hope and self-efficacy.

e) Provide appropriate and effective clinical case management services for Military Students and Families determined to be at need.

For all cases, SBH clinicians will actively determine whether Military students and their Families require clinical case management support. This would include cases that require additional services, are actively receiving other services, or are not receiving case management from school-employed staff. On an ongoing basis, clinicians should assess whether the student/family would benefit from a particular support or enrollment in a program or service (e.g., tutoring, job skills, employment-related, training, and mentoring). These clinical case management services should capitalize on other case management services available in the school, and through Army and community resources, reflecting the philosophy (presented earlier) of augmenting but not replacing or reducing utilization of existing services.

f) Provide implementation support to clinical staff in assuring effective evidence-based interventions.

Recent research has emphasized that traditional one-to-one or group supervision characterized by discussion of cases, is not effective in supporting evidence-based practice. Instead, there is significant movement toward implementation support, involving key components of lively teaching, demonstration and behavioral rehearsal of key skills, ongoing practice of those skills, demonstration of skills and feedback by a senior trainer or supervisor, peer-to-peer with emotional support, and administrative support, including replenishing files of key materials to support EBP (see Fixsen et al., 2005; Weist et al., 2009).

Implementation support should be provided to staff in weekly, "all hands staff meetings," with Deputy Directors assuring that these meetings have ample time for the above action strategies. During these days, PALs should assist the Deputy Director and Director in demonstrating, practicing and receiving feedback on Family Engagement and Empowerment Skills, on the evidence-based skills for targeted disorders (Depression, Anxiety, Trauma-Related, ADHD, and Disruptive Behavior Disorders (DBD), with Depression and Anxiety grouped together, and ADHD and DBD grouped together as described earlier). In addition, there should be regular review and implementation support for action strategies occurring for the three theme areas of Resilience, Wellness, and Effective Coping. Each week training and coaching will address each of the six areas and will more intensively address one of the areas (with a rotating schedule of each PAL taking the lead in training about once every six weeks). Off-site training will include observation of skills used in live therapy sessions with students and their Families, behavioral rehearsal and feedback for key skills, emotional support, discussion of cases, and administrative support.

Practice Elements for Youth with Behavioral and Emotional Needs – by Chorpita, B. F., & Daleiden, E. L. (2009). 2009 Biennial Report: Effective Psychosocial Interventions for Youth with Behavioral and Emotional Needs. Child and Mental Health Division, Hawaii Department of Health.

Anxious or Avoidant Behavior Problems	Attention and Hyperactivity	Autism Spectrum Disorders
•Exposure •Relaxation •Cognitive •Modeling •Psychoeducation-Child •Therapist Praise/Rewards •Self-Monitoring	•Problem Solving •Praise •Psychoeducation-Parent •Tangible Rewards •Stimulus Control/Antecedent Management •Commands	•Communication Skills •Modeling •Social Skills Training •Goal Setting •Attending •Maintenance/ Relapse Prevention
Depression and Withdrawal	**Delinquency and Disruptive Behavior (12 & under)**	**Delinquency and Disruptive Behavior (13 & over)**
•Cognitive •Psychoeducation-Child •Activity Scheduling •Maintenance/ Relapse Prevention •Problem Solving •Self-Monitoring	•Time Out •Praise •Tangible Rewards •Commands •Differential Reinforcement •Problem Solving •Psychoeducation-Parent	•Communication Skills •Problem Solving •Social Skills Training •Cognitive •Monitoring •Praise
Eating Problems	**Substance Use**	**Traumatic Stress**
•Family Therapy •Cognitive •Goal Setting •Problem Solving •Psychoeducation-Child •Psychoeducation-Parent	•Motivational Interviewing •Family Therapy •Cognitive •Psychoeducation-Child •Assertiveness Training •Communication Skills	•Cognitive •Exposure •Psychoeducation-Child •Relaxation •Maintenance/ Relapse Prevention •Psychoeducation-Parent

Goal 4: To ensure high quality, evidence-based prevention, intervention programs and services will be effectively delivered, evaluated and continuously improved

a) At the beginning of the school year, members of school Advisory Groups and Triage Teams will come together and complete the SBH Quality Assessment Questionnaire (Weist et al., 2006). See Appendix pg. 76 for a copy of this tool. The SBH Quality Assessment Questionnaire (SMHQAQ) was developed by Mark Weist and colleagues of the University of Maryland Center for School Mental Health (CSMH). The measure includes 40 indicators that assess different dimensions of effective SBH programming. The measure and resources for quality assessment and improvement for each of the 40 indicators can be found at: http://www.schoolmentalhealth.org/Resources/Clin/QAIRsrc/QAI.

The measure reflects 10 principles for best practice in SBH. Indicators are also categorized into 13 subgroups:

1) Access to care
2) Needs assessment
3) Addressing needs and strengths
4) Evidence-based practice: screening, assessment, and intervention
5) Stakeholder involvement and feedback
6) Systematic quality assessment and improvement
7) Continuum of care
8) Referral process
9) Clinician training and support
10) Clinician flexibility and responsiveness
11) Competently addressing developmental, cultural, and personal differences
12) Interdisciplinary collaboration and communication
13) Community coordination

Members from the two teams will ideally include a mix of people including the SBH clinicians, school psychologists, counselors, general and special education teachers, school principal or administrator, parent leader, and PBIS leader. Based on their knowledge of the school, these stakeholders will be asked to rate the degree that each indicator is developed and/or implemented using a six-point Likert scale, with 1 = "not at all in place" and 6 = "fully in place." Responses across raters will be scored and summarized, with notation of strengths (highly rated indicators) and challenge areas (low rated indicators). With summary findings from the measure, the team will then be asked to choose three areas for systematic improvement over the course of the school year, with improvement plans implemented by the clinician and key stakeholders involved.

b) Implement a clinical evaluation strategy.

The clinical evaluation will include completion of public domain measures by Families, students and teachers at structured intervals, and time series analyses on key variables from student academic records. Psychosocial measures will include:

- *Strengths and Difficulties Questionnaires* (see Appendix pg. 79-82)

The SDQ (www.sdqinfo.com) contains 32 items assessing student emotional and behavioral problems and strengths. It has strong psychometric qualities; free Internet based scoring and is being widely used in the U.S. and internationally.

- Key variables from student records (Detailed below)

We are emphasizing the use of public domain measures related to likely program expansion throughout the Army. Use of public domain measures will reduce costs, enable broader usage, avoid potential tension about copyrights, and avoid providing specific endorsement of a private sector product. In addition to this clinical evaluation strategy, individual providers may use other measures, including private sector measures to enhance evaluation and treatment for specific disorders. However, these measures will not be included in the program evaluation. The clinical evaluation strategy will be implemented for all cases involving a minimum of 4 assessment/treatment sessions. In addition, the total number of sessions provided to each family will be recorded to enable analyses of the outcomes for students/Families receiving more intensive intervention.

For students/Families that are determined to need and benefit from SBH, within the first two sessions, the two clinical evaluation measures (SDQ) will be collected. This measure will be completed by a parent/guardian at intake and again at three months, case closure, or the end of the school year, whichever comes first. In addition, the most knowledgeable teacher and students aged 11 and older will also complete the SDQ at both points in time. Based on presenting diagnosis, clinical judgment and other factors, other psychosocial measures will be used to enhance assessment of students receiving SBH services; however, these measures will not be included in the program evaluation.

In addition to the SDQ, a number of disorder-specific measures will be selected for use. These measures are not part of the clinical evaluation strategy but installations are strongly encouraged to use them versus other measures for more intensive assessment of youth presenting particular disorders. Guidance on specific tools and the time intervals for collection will be determined upon completion of the MEDCOM SBH System of Care campaign planning process. Please contact CAF-BHO staff if you are interested in learning more.

Given agreements with the local school districts or departments of education to access relevant data from school records, quarterly data from academic records should be tracked for students participating in the program. Please note that the ability to access this data will vary by community and by individual school. At each school, all cases that have been seen four or more times will be listed. Three cases per SBH clinician will be randomly selected using a stratified random assignment procedure, to include student age, cultural/ethnic background, gender and presenting problem.

For each academic quarter and/or semester data should be collected on:

- Total number of student unexcused absences
- Total number of student tardies
- Total number of discipline encounters
- Total number of and reasons for school suspensions
- Overall quarterly (not semester) grade point or letter grade average

Quarterly numbers or letters, for each of these variables, will be organized for individual students, preferably including four academic quarters prior to intervention to represent baseline levels of performance. Analyses will then be conducted for within student changes in these variables over time, before and after intervention, and then comparisons made across students, given differing points of intervention that enables more stringent multiple-baseline-across-students analyses. Scoring and visual display software should be obtained to facilitate these analyses. Note that SBH staff should, if at all possible, begin this work in the spring with data organization, analyses and report generation activities to occur over the summer for the prior academic year, with this cycle repeating each summer.

In addition to collection of the psychosocial and school record measures as above, data will be collected from the sponsoring Army MTF. This should include a measure of satisfaction of services completed by Military Families, such as the revised Interactive Consumer Evaluation (see Appendix pg. 83) reflecting parent/guardian satisfaction with services and perceived impact on dimensions of family emotional functioning, stress, ability to handle work/home responsibilities, and ability to handle deployment-related stress. Army MTF records could also be used to track the receipt of more intensive services by students/Families receiving SBH services (e.g., additional intensive outpatient services, psychiatric hospitalizations).

c) Develop and implement strategies to assure that student-level evaluation findings actively inform evolving treatment planning and monitoring.

Summary scores and profiles of the SDQ, other measures collected, staff and family reports, and observation of the student will be actively used by clinicians and by the Triage Team to ensure the fluid adjustment of treatment planning and clinical services to the changing needs of students and Families.

d) Organize program evaluation data, including process data collection, clinical evaluation findings across students, and analyses of changes in student school performance. Share summarized program evaluation data with the Advisory Council to assist in continuous quality improvement efforts.

Program evaluation data will be organized in all relevant dimensions, including process data, clinical evaluation findings across students and analyses of changes in student school performance. Process dimension data for all schools will assess the same variables including:

- Number of students referred
- Number of students seen
- Average latency between referral and services
- Number of health promotion training sessions
- Number of prevention groups
- Number of teacher consultations and other as indicated

Clinical evaluation data (SDQ, etc.) will be presented for all students who have at least one complete set of pre-post data collections (i.e., student, family, and/or teacher) at intake and Time 2 for at least one of the measures (SDQ or measure of family functioning). Student/Families will be given identifier numbers, and these numbers and corresponding data will be entered into Excel data bases, converted into SPSS files for statistical analyses, focusing on score changes from intake to Time 2, and considering other relevant variables in analyses (e.g., age, gender, diagnosis, number of treatment sessions). These findings will be organized by school, and across schools with guidance from the CAF-BHO Advisory Council, which will include university researchers.

The period of time between school ending one academic year and the beginning of the next academic year, will reflect an intense focus on program evaluation and organizing of program findings. Reports will be generated for each of the schools, including the above evaluation dimensions, and an overall report for the combined number of schools will be presented at each of the school's Advisory Group meetings and at the Installation Advisory Council meetings by mid fall. This will enable the processing of the evaluation findings so that recommendations for program improvement can be made. In addition, a summary report of findings across Installations will be organized for the CAF-BHO Advisory Board to be reviewed at the annual meeting in the fall. The CAF-BHO will develop Annual reports each year on SBH progress; based on processes reviewed here, we anticipate that the fall report will be the most comprehensive, setting the stage for action strategies over the course of that year. This cycle will continue in each year of the initiative, with CAF-BHO Annual reports serving to integrate evaluation findings across Installations, and facilitating continuous quality improvement and growth in capacity.

e) Assure that developed program materials and plans for promotion and intervention undergo stakeholder credibility checks to ensure they are acceptable and meet identified needs for Military Students and Families, as well as Military and school leaders.

Throughout the year, and coinciding with the above reporting and organization of Annual reports on the broader SBH initiative by CAF-BHO, all installations, through their Advisory Councils, should be seeking active input from diverse stakeholders on program progress. Council members will be asked to rate plans and materials in relation to their importance and expected impacts for Military Families served by their SBH program. Based on these ratings, plans and materials will be adjusted and refined to best match the needs of local stakeholders and in relation to current issues of Military life.

Goal 5: To conduct training and build school and community support for effective SBH for Military Students and Families

a) Expand externship, internship and fellowship opportunities for BH disciplines on effective SBH for Military Families.

An SBH staff person will make every effort, whenever possible, to conduct outreach activities with local universities and colleges that offer graduate training for disciplines such as child and adolescent psychiatry; clinical, counseling, and school psychology; and social work. Relationships will be developed with these training programs toward expanding the number of trainees placed in schools, working alongside experienced clinicians. This will add to the staffing complement of the programs and provide important training on effective SBH for participating students.

Trainees will participate in weekly supervision and training meetings of the SBH program, and will be invited to participate in other training (e.g., by departments of education, and mental health) as possible. All trainees will have a licensed supervisor and experienced SBH clinician matched to the particular needs of their training program. The program will emphasize working side by side with other BH disciplines, educators and family members. All training will be interdisciplinary.

b) Conduct training on effective SBH and its benefits to Military Families at local, regional and state levels.

At each site, based on experiences and resources, training events will be organized for the local installation, surrounding community, and through connections established with state systems of education and mental health. SBH training for Military Families should be integrated into regional and state level conferences and meetings. These trainings will help raise the visibility of and support for SBH efforts for Military Families.

Goal 6: To expand and improve SBH services for Military Students and Families through organized advocacy and policy influencing actions

a) Build relations within the school leadership, Military, community, and with youth serving agencies to gain their support for this agenda.

Installation Advisory Councils should lead the agenda for relationship development and expansion toward more comprehensive and inclusive school, Military and community representation. The Council will set the tone of building interdisciplinary and interagency collaboration and mutual support toward program improvement and expansion. In addition, Council members should view themselves as emissaries of the initiative, and as possible, participate actively in local and state workgroups, committees and task forces focused on improving BH and education for Children and adolescents, and those focused on strengthening Families.

b) Participate actively in the National Community of Practice on Collaborative SBH sponsored by the IDEA Partnership and the University of Maryland Center for School Mental Health.

The Community of Practice (COP) on Collaborative SBH (see www.sharedwork.org) is active in 16 states. The COP is sponsoring a range of discussions, and collaboration toward building the SBH agenda at these states. Program leaders should ensure that SBH for Military students and Families is a prominent agenda within the COP, and participate actively in the practice group of the same. In conjunction with the COP, an annual conference on SBH for Military Families occurred in 2010, with plans for this to continue and connect leaders and clinical staff from SBH programs from around the nation and in other nations.

c) Use social marketing strategies to optimally present the initiative and to build broad-based support for SBH (e.g., compelling brochure and documents, use of media).

Experts in social marketing should be involved in providing guidance to develop documents, training events, websites, etc. to ensure that marketing products are the most compelling and will build interest for this agenda. Systematic efforts to engage the media and to have stories (print and television) should also be prioritized. All social marketing efforts should consider the most compelling messages for Military students and Families in dealing with the ARFORGEN cycle, the benefits of SBH in this cycle and to supporting positive behavior and academic success during cycles of the school calendar.

VIII. REFERENCES

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IX. GLOSSARY OF TERMS

(ACS) Army Community Service - Organization on each installation that coordinates and provides family services, such as Child, Youth and School Services, EFMP support services, Military housing, community activities, etc. http://www.myarmyonesource.com/default.aspx

(AHLTA) Armed Forces Health Longitudinal Technology Application - Formerly **CHCS II.** The Military's electronic health record (EHR), AHLTA, is an enterprise-wide medical and dental information management system that provides secure online access to Military Health System (MHS) beneficiary's records. It is used by medical clinicians in all fixed and deployed Military Treatment Facilities (MTFs) worldwide. This centralized EHR allows health care personnel worldwide to access complete, accurate health data to make informed patient care decisions - at the point of care - anytime, anywhere. AHLTA is the first system to allow for the central storage of standardized electronic health record (EHR) data that is available for worldwide sharing of patient information.

(ARFORGEN) Army Force Generation - The Army's operational rotational model in which groups of Soldiers predictably cycle; reset, train/ready, and available. Military family programs align and coordinate resources and services with the cycle to provide support to Children and Families during the time of greatest need. http://www.army.mil/aps/08/addenda/addenda_e.html

(CAFAC) Child and Family Assistance Center - Outpatient BH services and resource center for Military Children and Families, such as; individual group, family and marital therapy, counseling, psychiatric, and coordinated care.

(CAF-BHO) Child, Adolescent & Family Behavioral Health Office - Formerly known as the Child, Adolescent & Family Behavioral Health Proponency (CAF-BHP) and the Military Child & Adolescent Center of Excellence (MCA-COE). A division of Army Medical Command, Office of the Surgeon General, United States Army, which coordinates, develops, and implements BH systems of care, for Military Children and Families, to include SBH programs, within the Army, world-wide.

(CBT) Cognitive Behavioral Therapy - A psychotherapeutic approach, a talking therapy, which aims to solve problems concerning dysfunctional emotions, behaviors and cognitions through a goal-oriented, systematic procedure.

(CDC) Child Development Center - Day care center within the gates of a Military installation, usually providing care for infants through school-age children.

(CPSD) Clover Park School District – Washington state school district collaborative partner of JBLM SBH programs. See example of MOA/MOU. http://www.cloverpark.k12.wa.us/

(CSMH) Center for School Mental Health - University of Maryland civilian leader in SBH programming and curriculum development. Hosts the annual Advancing School Mental Health national conference. http://csmh.umaryland.edu/

(DoD) Department of Defense - Department within the United States government in which all branches of Military, commands and programs falls under and are directed by. http://www.defense.gov/

(DoDEA) The **Department of Defense Education Activity -** Civilian agency of the United States Department of Defense that manages all schools for Military Children and teenagers, as well as foreign service Children and teenagers, in the United States and also overseas at American Military bases worldwide. http://www.dodea.edu/home/

(EBP) Evidence Based Practice or **empirically-supported treatment** (**EST**) **-** Refers to preferential use of mental and BH interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.

(EFMP)Exceptional Family Member Program - A mandatory U.S. Department of Defense enrollment program that works with other Military and civilian agencies to provide comprehensive and coordinated community support, housing, educational, medical, and personnel services worldwide to U.S. Military Families with special needs. Service members on active duty enroll in the program when they have a family member with a physical, *developmental, emotional or BH disorder* requiring specialized services so their needs can be considered in the Military personnel assignment process. The profile is initiated by the diagnosing or treating physician and *must* be updated when a condition changes or every three years, at a minimum. http://www.apd.army.mil/pdffiles/r608_75.pdf

(EHR) Electronic Health Record - Also known as **(EMR), or Electronic Medical Record.** Computerized documentation of an individual's medical data. Each Military and family member have an individual record categorized by the service members social security number, then identified by a prefix specific to each family member.

(FERPA) Family Educational Rights and Privacy Act of 1974 **-** Also known as the **Buckley Amendment.** Provide that educational agencies and institutions that receive funding under a program administered by the U. S. Department of Education must provide students with access to their education records, an opportunity to seek to have the records amended, and some control over the disclosure of information from the records. With several exceptions, schools must have a student's consent prior to the disclosure of education records. Examples of situations affected by FERPA include school employees divulging information to anyone other than the student about the student's grades or behavior, and school work posted on a bulletin board with a grade.
http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

(FY) Fiscal Year - Also known as **Financial Year.** Calendar in which business and government budget accounting are run, starts 01 Oct yearly. Each FY is broken further into Quarters 1-4, each consisting of 3 month intervals.

Garrison - Base, post, or installation command, similar to a city government

(HIPAA) Health Insurance Portability and Accountability Act 1996 - Provides the ability to transfer and continue health insurance coverage for millions of American workers and their Families when they change or lose their jobs; Reduces health care fraud and abuse; Mandates industry-wide standards for health care information on electronic billing and other processes; and Requires the protection and confidential handling of protected health information. http://www.hhs.gov/ocr/privacy/

(ICE) Interactive Consumer Evaluation - Electronic survey used by the DoD allowing customers to rate products and services provided by DoD offices and facilities worldwide. Comment card ratings are used to improve the products and services available to service members and Families. Specialized accounts may be established to report feedback to multiple or individual reviewers. http://ice.disa.mil/

(IDEA) Individuals with Disabilities Education Act - US federal law that governs how states and public agencies provide early intervention, special education, and related services to Children with disabilities. It addresses the educational needs of Children with disabilities from birth to age 18 or 21 in cases that involve 13 specified categories of disability. http://idea.ed.gov/

(IMCOM) - Installation Management Command - Military command group responsible for all Garrison installation non-operational activities, such as; Army Community Service, Child, Youth, and School Services, Child Development Centers, family programs and infrastructure.
http://www.imcom.army.mil/hq/

(JAG) Judge Advocate General - Office of legal counsel for the United States Military. Any/all legal questions, protocol, MOA/U, release of information, or documents must be routed through this office for approval. Located at each Military Treatment Facility and post/base command.

(JBLM) Joint Base Lewis-McChord, WA - Formerly Ft. Lewis Army installation and McChord Air Force Base, home base of the Child, Adolescent &Family Behavioral Health Office. http://info.lewis-mcchord.army.mil/

(MEDCOM) United States Army Medical Command - Major command of the U.S. Army that provides command and control of the Army's fixed-facility medical, dental, and veterinary treatment facilities, providing preventive care, medical research and development and training institutions. Commanded by the Army Surgeon General, this command is responsible for all medical programs and activities within the Army. http://www.armymedicine.army.mil/

(MFLC) Military Family Life Consultant - Contracted licensed Social Workers who provide education and information on Family dynamics, parenting strategies, available support services, the effects of stress, and positive coping mechanisms. MFLCs provide anonymous and confidential assistance to Soldiers and their Families in problem solving issues resulting from deployment, reunions, reintegration, and/or other times of change. Community collaborative partners of School BH programs.
https://www.mhngs.com/app/programsandservices/mflc_program.content

(**MHS) Madigan Healthcare System -** Formerly **Madigan Army Medical Center (MAMC)**, located at Joint Base Lewis-McChord, WA. Serves as the United States Army Western Regional Medical Command and MTF home of the JBLM SBH program. MHS is one of the largest hospitals on the west coast of the US.
http://www.mamc.amedd.army.mil/

(MOA/MOU) Memorandum of Agreement/Understanding - A legal document used to define collaborative roles and responsibilities between a medical treatment facility, local school districts, and the government, in developing, implementing, and sustaining a SBH program.

(PBIS) Positive Behavioral Intervention Support - Social/behavioral strategy with major emphasis on a multi-level prevention system, systematic screening of youth for early problems, active progress monitoring, and data-based decision making. http://www.pbis.org/

(PH/TBI) Psychological Health/Traumatic Brain Injury - Department of specialty within MEDCOM to assess, validate, oversee and facilitate prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for USA's Military communities, warriors and Families, affected by these specific disabilities.

(SBH) School Behavioral Health – Previously known as School Mental Health. Term used as a title or descriptor for programs providing behavioral health services within a school setting. The United States Army has issued official guidance that all programs and references to "mental" health, should be changed to "behavioral" health.

(SMHQAQ) School Mental Health Quality Assessment Questionnaire - A research-based measure designed to help clinicians, administrators, and others invested in school mental health to assess strengths and weaknesses within their school mental health services and programming. Quality indicators are based on the Ten Principles for Expanded School Mental Health. Findings from the measure can assist in identifying priority areas for improving school mental health services.
http://www.schoolmentalhealth.org/Resources/Clin/QAIRsrc/QAQ.pdf

(SDQ) Strength and Difficulties Questionnaire - A brief behavioral screening questionnaire, for Children ages 3 to 16, that provides reliable information of about 25 attributes, some positive and others negative. The 25 items are divided between 5 scales of 5 items each, generalizing scores for conduct problems, hyperactivity, emotional symptoms, peer/relationship problems, and pro-social behavior. Impact supplements exist for parents, teachers, and older Children. FREE online scoring is available at http://www.sdqscore.org/

(SLO) School Liaison Officer - Usually located within Army Community Services (ACS), Child, Youth, and School Services (CYSS)division, providing general advocacy for the educational needs of Military Children through networking and partnering with the public school system and districts, private schools and home schools.

(TAMC)Tripler Army Medical Center - Located in Honolulu, HI, home of the United States Army Pacific Regional Medical Command and all Hawaii SBH programs. TAMC is the largest MTF in the Asian and Pacific Rim areas. http://www.tamc.amedd.army.mil/

(TDY) Temporary Duty - A temporary state of work away from a normal duty station, such as going to a conference or meeting out of the local area.

(TJC)The Joint Commission formerly the **(JCAHO) Joint Commission on Accreditation of Healthcare Organizations -** An independent, not-for-profit group in the United States that administers accreditation programs for hospitals and other healthcare-related organizations. The Commission develops performance standards that address crucial elements of operation, such as patient care, medication safety, infection control and consumer rights. http://www.jointcommission.org/

X. APPENDIX

DEPARTMENT OF THE ARMY
MADIGAN ARMY MEDICAL CENTER
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

MCHJ-104-10

REPLY TO
ATTENTION OF

MEMORANDUM OF AGREEMENT
BETWEEN
MADIGAN ARMY MEDICAL CENTER, TACOMA, WA
AND
CLOVER PARK SCHOOL DISTRICT

SUBJECT: School Based Health Team (SBHT) for Military Children and Adolescents in the Clover Park School District.

1. References.

   a. DODI 4000. 19, Defense Regional Interservice and Intergovernmental Support (DRIS) Program, 9 Aug 1995.

   b. DOD 6025. 18-R, DOD Health Information Privacy Regulation (HIPAA), 24 Jan 2003.

   c. Report of the DoD Task Force on Mental Health, "An Achievable Vision," June 2007.

   d. American Psychological Association (APA) Presidential TaskForce on Military Deployment Services for Youth, Families and Service Members, 18 February 2007.

   e. Army Family Covenant (SECDEF), 17 October 2007.

2. Purpose. This Memorandum of Agreement (MOA) between the Commander, Madigan Army Medical Center (MAMC), Child, Adolescent, and Family Behavior Health Proponency (CAFBHP) and the Superintendant of Clover Park School District, herein referred to as CPSD, is established to provide consultation and training for school staff. and to offer behavior health services to military dependent children and adolescents, herein referred to as students attending Beachwood Elementary, Clarkmoor Elementary, Evergreen Elementary, Greenwood Elementary, Hillside Elementary and Carter Lake Elementary School ("Covered Schools"). The MAMC School Based Health Team (SBHT) will provide: Evaluations, screenings, prevention, early identification, risk reduction, tertiary intervention, medically related evaluations, psychiatric and medication management services, behavior health services, individual therapy, group therapy, family education, case management, psychological services, consultation, early intervention and clinical evaluations to students and their families.

3. Background. School behavior services have been successfully implemented at other military installations across the nation in collaboration with civilian and Department of Defense Educational Activity (DODEA) schools.

4. Scope.

a. Effective as of Fiscal Year (FY) 2010, this agreement provides MAMC:

b. Funds for the Covered Schools in compliance with the Post-Traumatic Stress Disorder-Traumatic Brain Injury/ Behavioral Health Integration (PTBI) Office increase in funding for use towards SBHT Programs. Services may continue with or without PTBI funding and may be reduced to prior FY 2010 funding levels.

c. Any research project or study proposed or conducted by MAMC will be addressed in other documentation and in accordance with MAMC and CPSD research and study guidelines.

d. This Agreement reflects no cost or funding exchange between MAMC and CPSD, and does not involve the use of contracted service providers. This Agreement is not a project, study, or research initiative and does not involve any cooperative research. Any research project or study will be addressed in other documentation.

e. SBHT and CPSD will jointly work to provide clinical evaluations, psychiatric services, psychological services, and intervention support for military students and their families attending the Covered Schools. These services are in addition to services required to be provided by the CPSD, pursuant to the Individuals with Disabilities Education Improvement Act (IDEIA) and section 504 of the Rehabilitation Act.
Services provided by the SBHT will not be considered an entitlement to the student beyond the terms of this Agreement.

f. The School District Area Superintendent (SDAS) or designee, as authority for the CPSD, and the MAMC Chief, Child and Adolescent Center of Excellence (CAFBHP) or designee, as authority for MAMC, will provide oversight and general supervision of the SBHT Program at the Covered School sites to ensure that educational mission and responsibilities are adhered to as specified in state and federal law, Board of Education policies, and departmental regulations.

g. For the purposes of the SBHT Program, the student must be a military dependent and enrolled in one of the Covered Schools identified in this Agreement. The family member of the student participating in the services must be the parent or legal guardian of the student and must be an active duty member of the armed services or a military dependent. In order for a student and his/ her family to qualify to receive services in this program, the parent or legal guardian must provide informed consent for the services and for the full sharing of information between SBHT and the CPSD.

h. The Referral Guidelines for SBHT Program as described in Attachment 1 incorporates evidence-based practices and will be utilized when a student exhibits learning and/or emotional behavioral difficulties that have academic implications. (See Attachment 1)

i. All information regarding a student or family will be treated with confidentiality in accordance with Family Educational Rights and Privacy Act, 34 C.F.R. part 99 (FERPA), HIPAA, and all other State and Federal confidentiality laws and regulations to ensure appropriate protection of student rights. MAMC's SBHT will abide by the Confidential Information Guideline as described in Attachment 2. (See Attachment 2)

j. Services provided by the SBHT Program, as well as its personnel, are independent of the services provided by the CPSD. The SBHT Program is an outside agency providing adjunct non-mandated services to military dependents and their families. All evaluations and services conducted by the SBHT Program are adjunct to evaluations and services provided by the CPSD and will be treated as independent evaluations and services.

k. Both SBHT and CPSD agree to share information related to the day-to-day operations that may adversely impact the well-being of the student or the family members receiving services through the SBHT Program. In addition, School Principals or designees and SBHT Director or designee shall meet at least monthly to address any issues and concerns relating to the operations of the SBHT Program.

l. If a concern for an eligible student is raised and the CPSD process has been followed, the parent/guardian will be provided with written material developed by MAMC that explains the SBHT program, services and process used to screen for behavior health problems. If the parent/guardian expresses interest in utilization of SBHT services, written parental consent will be obtained prior to any exchange of written or verbal information regarding the student. The consent form shall provide parents/guardians with an explanation of the array and scope of services provided by the SBHT, shall acknowledge that these services are not mandated or an entitlement, and shall provide for full information sharing between SBHT and CPSD. Once parental consent is obtained, a SBHT/ CPSD School Triage Team meeting may be held to discuss and review the need for behavioral health services and to consider how SBHT services can be provided in conjunction with services from the CPSD.

m. A SBHT/ CPSD School Triage Team will be established at each of the Covered Schools in this Agreement and participants should include, but are not limited to the School Administrator (or designee), CPSD Clinical/School Psychologists, School Counselors, School-Based Behavioral Health Staff (SBHS), SBHT, and as by invitation of the SBHT/ CPSD School Triage Team, other individuals involved in the care of the student, including the parent/guardian. The purpose of the School Triage Team is to identify and

review individual cases that are referred by SBHT or the school as needing behavioral health services and interventions.

n. A School Advisory Group will be established at each of the Covered Schools in this Agreement to provide guidance to the SBHT Program at that particular school, and to assist in the development and delivery of programs and services at the school level. Membership in Advisory Group will minimally include the school principal, SBHT staff, CPSD/ SBHT psychologists, and may also include SBHT staff, counselors, teachers, parent representatives, and other individuals closely involved in provision of SBHT services. Each School Advisory Group should meet at least monthly.

o. An Advisory Board will be established to provide guidance and oversight to the SBHT program operations and practices. Members on the board will include key representatives from such role groups as the CPSD, Department of Health (DOH), the Department of Defense (DOD), the Department of the Army (DA), parent representatives, and other community leaders.

5. Understandings, agreements, support and resource needs.

Madigan Army Medical Center will:

a. Develop an interim guideline within three months of the approval of this MOA and submit to the Point of Contacts (POC) listed on this MOA. The operational guideline for the SBHT Program will be created jointly with the School Advisory Group and other key stakeholders such as the CPSD, CPSD designee, CPSD personnel, and SBHT district staff. The operational guideline may contain, but is not limited to program description, services, parent information, referral procedures, informed consent forms used, communication with parents and school staff, SBHT staff roles and responsibilities, supervision of SBHT staff, transitioning of services, collaboration with CPSD, and treatment planning (addressing initiation of services, intensity and severity of services, service reviews, terminations, providers, etc.)

b. Provide clinical oversight and supervision of SBHT staff members.

c. Complete the operational guideline within one year of the approval of this Agreement and submit to the POCs listed on this MOA. The operational guideline for the SBHT will be reviewed by the MOA POCs, School Advisory Group, Advisory Board and other key stakeholders, and/or revised annually or as frequent as necessary.

d. Provide services to students who meet the SBHT criteria for referral in concurrence with CPSD referral process, as well as IDEIA/504 mandate, including students with

disabilities in accordance with best practices and standards of care accepted by the MAMC and CPSD.

e. Ensure, via MAMC Intell and Security Division and the Credentials Office, that staff members are academically qualified and possess the appropriate credentials and background checks to provide behavioral health evaluations, clinical treatments, and training to members of the school staff and the family of the student. SBHT personnel will comply with CPSD rules and regulations, and CPSD policies and procedures of conduct when on the CPSD premises.

f. Provide consultative services, which are consistent with CPSD SBHT practices, to teachers and other members of the school staff to integrate the intervention strategies into the regular classroom curriculum or routine, as agreed upon by School Principals at each location and in alignment with CPSD.

g. Provide computers, printers, blood pressure machines, weight scales, clinical or evaluation forms for treatment and intervention, therapeutic toys and games, clinical manuals and text, office and art supplies for the use of SBHT staff members. Materials will be purchased through PTBI funds and will remain the property and responsibility of MAMC.

h. Provide training to CPSD teachers and other staff at the request of the school principals, and in accordance with CPSD SBHT Staff, as appropriate. The training is to inform the CPSD teachers and staff on social, emotional and behavioral issues related to military beneficiaries.

i. Meet regularly with school principals and other Advisory Group members to coordinate the services provided to the eligible students and family members, and to work together toward enhancing program planning, collaboration, and performance.

j. Provide crisis management care and behavioral management by appropriately credentialed and trained staff to ensure the safety and well-being of students and families receiving services from SBHT providers. When a sentinel event occurs, the SBHT staff will manage, document and communicate with school staff, parents/guardians, and other applicable appropriate individuals or agencies (i.e. Child with Welfare Services, Tacoma Police Department, Department of Health, etc.) regarding the sentinel event and provide follow-up care.

k. Obtain prior written consent from the parent/legal guardians of the student to participate in the SBHT Program. The consent shall include, consent for SBHT and the CPSD to share all necessary and relevant information regarding the student and his/her family.

l. Share information regarding the SBHT services provided to students enrolled in the program with parents/legal guardians, CPSD, teachers and SBHT staff.

m. Share any reports, findings or information provided to funding sources or other agencies (outside of CPSD) with the CPSD regarding the service provision, program monitoring and program evaluation of the SBHT Program within two weeks of submission of such reports.

6. Military healthcare providers affected by this agreement provide healthcare services under authority of lawful orders issued by the Department of the Army and receive their pay and allowances therefrom. Accordingly, while performing such services, military healthcare providers are acting within the scope of their employment and are considered employees of the Army acting within the scope of their employment under Federal law. The provisions of 28 United States Code, section 2679, will immunize the military healthcare providers from individual tort liability. Furthermore, it is understood by CPSD that the United States will protect the liability of the military providers only, and that the United States may, in its representation of the military providers, assert any defense available under Federal law. Any notification of an actual or potential claim or suit against CPSD which names a military healthcare provider resident as a party of potential defendant will be reported to the United States Army Claims Service, Fort George G. Meade, Maryland 20755 (telephone (301) 677-7009). To the extent allowed by law the CPSD agrees to cooperate fully with the United States in the investigation of such complaints. Further, CPSD will notify the United States of the extent and nature of any applicable malpractice insurance and whether such insurance includes the military providers. The United States Army will cooperate in the investigation and defense of such complaints and where concurrence of the Attorney General is obtained will, upon request of the military providers, assist in the removal of the action to the appropriate Federal District Court with a view toward substituting the United States as a defendant in lieu of the military providers.

7. Clover Park School District will:

a. Ensure School Principals provide day-to-day administrative oversight of the SBHT Program based at the school and on-site administrative supervision of SBHT employees and services.

b. Provide adequate space and facilities on the school campus, as available, to the extent practicable, in order for the SBHT to conduct appropriate evaluations and provide the services to the student and family members.

c. Continue to provide any IDEIA or section 504 services identified through the Individualized Education Plan for those students who meet the eligibility requirements.

d. MAMC and CPSD mutually agree and acknowledge that, under this agreement: (1) No agent, servant, or employee of the Unites States Government shall be deemed an agent, servant, or employee of the State of Washington, or be permitted to perform services of any kind on behalf of the State of Washington; and (2) no agent, servant, or employee of the State of Washington shall be deemed an agent, servant, or employee of the United States Government.

e. The CPSD shall be responsible for damages or injury caused by agents, officers, and employees in the course of their employment to the extent that the CPSD liability for such damage or injury has been determined by a court or otherwise agreed to by the CPSD, and the CPSD shall pay for such damages and injury to the extent permitted by law.

8. Primary Points of Contact

Debbie LeBeau
Superintendent of CPSD
Lakewood, WA 98431
253-583-5190
supt@cloverpark.k12.wa.us

Josh Zarling
Principal of Beachwood Elementary School
Lakewood, WA 98431
253-583-5200
jzarling@cloverpark.k12.wa.us

Molly Click
Principal, Clarkmoor Elementary School
Lakewood, WA 98431
253-583-5220
mclick@cloverpark.k12.wa.us

Holly Shaffer
Principal, Evergreen Elementary School
Lakewood, WA 98431
253-583-5250
hshaffer@cloverpark.k12.wa.us

Harjeet Sandhu-Fuller
Principal, Hillside Elementary School
Lakewood, WA 98431
253-583-5280
hsandhu@cloverpark.k12.wa.us

Angela Wolfe
Principal, Greenwood Elementary School
Lakewood, WA 98431
253-583-5260
awolfe@cloverpark.k12.wa.us

Paul Douglas
Principal, Carter Lake Elementary School
Lakewood, WA 98431
253-583-5210
pdouglas@cloverpark.k12.wa.us

Dr.Michael Faran
Director, CAFBHP
Tacoma, WA 98431
253-968-4745
Michael.faran@amedd.army.mil

COL Kris Peterson
Chief, Department of Psychiatry
Tacoma, WA 98431
253-968-2783
kris.peterson@amedd.army.mil

9. Effective Date, Review, Disputes and Termination.

a. This Agreement shall be effective upon signature of both parties and will remain in effect until formally terminated.

b. For effectiveness, each party will evaluate this Agreement annually to ensure continued accuracy. Modifications desired by either party are to be requested in writing at least 90 days in advance of the proposed effective date. Both parties must agree to modifications and such agreement shall not be unreasonably withheld.

c. Both parties to this Agreement concur with the level of support and resource commitments.

d. Disputes shall be resolved at the lowest level possible. The CPSD Principal and SBHT Staff, including SBHT staff supervisors if necessary, shall resolve any disagreements at the school level. If the dispute cannot be resolved, the CPSD Superintendent and the MAMC Chief, Child and Adolescent Center of Excellence shall resolve the issue. In the event resolution is not accomplished, the signatories to this Agreement will resolve the dispute.

e. This Agreement may be terminated at any time by mutual consent of the parties. This Agreement may also be canceled by either party upon giving at least 90 days written notice to the other parties. However, MAMC reserves the right to suspend or terminate services without notice if necessary in order to meet urgent military operational requirements. In case of mobilization or other military emergency, this MOA will remain in force only within MAMC capabilities.

(1) Transition plans shall be developed by SBHT with assistance from and collaboration with the School Triage Team for all students and families affected by the termination of services.

(2) Upon termination, all equipment, materials and supplies shall remain the property of the purchasing party.

CLOVER PARK SCHOOL DISTRICT

Debbie LeBeau
Superintendent, Clover Park School District

2-8-10
Date

Josh Zarling
Principal, Beachwood Elementary School

Molly Click
Principal, Clarkmoor Elementary School

Holly Shaffer
Principal, Evergreen Elementary School

MADIGAN ARMY MEDICAL CENTER

Jerome Penner III
Colonel, U.S. Army
Commanding

8 Mar 10
Date

Dr. Michael Faran,
Director, Military Child and Adolescent Center of Excellence

Colonel Kris Peterson
Chief, Department of Psychiatry

Angela Wolfe
Principal, Greenwood Elementary School

Harjeet Sandhu-Fuller
Principal, Hillside Elementary School

Paul Douglas
Principal, Carter Lake Elementary School

ATTACHMENT 1

Referral Guidelines
For
School-Based Behavioral Health Program

The CPSD and MAMC shall use the following referral process. The referral process will follow guidelines established between MAMC and the SBHT program, and will incorporate evidence-based practices and accepted CPSD and MAMC Standards of Practice.

1. A student may be referred for SBHT services by a teacher, counselor, School-Based Behavioral Specialist, and other CPSD staff, parent, or SBHT personnel. Typically, at the school, the principal will be informed of the concerns, and a Student Support Team (SST) will be convened to determine whether a referral to MAMC is warranted.

2. CPSD and MAMC shall obtain written consent from the parent/guardian prior to any exchange of information between CPSD and MAMC regarding a student. The consent form must comply with the Confidential Information Guideline as Attachment 2 of this Agreement, the FERPA, 34 C.F.R. part 99, and Health Insurance Portability and Accountability Act (HIPAA). The CPSD to obtain consent for release in receipt of information to and from MAMC providers.

3. If recommended by the SST, a CPSD/ MAMC School Triage Team will be informed of student needs, and recommend the most appropriate responses to those needs. Reports summarizing evaluation results and treatment planning will be provided to and maintained by the CPSD/ MAMC School Triage Team at each site.

4. If MAMC intervention services are warranted, an intervention plan will be developed by a CPSD/ MAMC School Triage Team, including the parent and teacher of the student, if applicable.

5. The CPSD will continue to be responsible for evaluating students to determine eligibility under IDEIA or section 504 of The Rehabilitation Act of 1973. If a MAMC evaluation of an eligible student receiving IDEIA or 504 services reveals information that may be pertinent to the provision of a free appropriation public education (FAPE) for that child, the MAMC evaluation shall be shared with the school and in accordance with an Individualized Education Program (IEP). Team meeting will be convened to consider the MAMC evaluation and information.

ATTACHMENT 2

Confidential Information Guideline
Confidentiality Obligations

i. While performing under this Agreement, and with parent or adult student consent MAMC may receive, be exposed to or acquire CPSD confidential information. Such information may include names, addresses, telephone numbers, birth dates, Social Security numbers, medical information, and other educational, student, or parent employment information. That information may be written or an oral interview, fixed in hard copy or contained in a computer database or computer readable form. Hereinafter, such language shall be collectively referred to as "Confidential Information."

ii. MAMC, including its employees, agents, representatives, and assigns, shall not disclose to any unauthorized party any confidential information, except as specifically permitted by the CPSD. Any such disclosure shall be subject to the restrictions of the Family Educational Act and Privacy Act, as well as any other legal limitations imposed by the State of Washington, to protect confidential information. MAMC shall permit access to confidential information only to those of its employees, agents, representatives, and assigns who have a specific need to know this information to perform services under this Agreement. MAMC shall advise each of its employees, agents, representatives, and assigns of their obligations to protect the confidentiality of any confidential information entrusted to them.

iii. MAMC, its employees, agents and representatives shall ensure the security of the CPSD confidential information. MAMC shall provide the CPSD with a list of individuals (by name and position) who are authorized to handle the CPSD confidential information (hereinafter referred to as "authorized handlers"). Authorized handlers shall ensure the security of the confidential information. Only authorized handlers shall have access to the confidential information, which will be kept on password-protected computers with the hardcopy documents kept in a locked file cabinet. MAMC shall ensure that procedures exist to prohibit access to the confidential information by anyone other than an authorized handler.

iv. MAMC will safeguard the confidentiality of all confidential information that it receives from CPSD and shall protect such documents from unauthorized use, handling, or viewing. MAMC shall return to CPSD all documents containing CPSD confidential information upon completion of the services provided by MAMC under this Agreement.

a. Prior written approval: MAMC may not share, publish, or distribute confidential information or any other data received under this Agreement, without the prior written approval of the State of Washington and CPSD.

b. In the event of termination of this Agreement, MAMC shall return to the state of Washington all student information received under this Agreement and further agrees to destroy any and all copies, or references to, any student information shared by State of Washington as a result of this Agreement.

Behavioral Health Survey – School Version

We would like your opinion regarding the available behavioral health support resources for families at JBLM Schools. Please answer as openly as you can; results of this survey will be used to make recommendations about how to improve services in these areas. The survey will only take about 5-10 minutes, and your opinions will be completely confidential. You will not be identified in the results.

FIRST, please tell us about yourself:

What is your current position in the school?_____
How many years have you been at your current position?_____
How many years have you been at this school?_____
How many years have you been employed by CPSD?_____
How many years have you been in the education field?_____
If you are a teacher, what grade(s) or subject do you teach?_____

NOW, answer the following questions about your school. Please read each statement and tell us how much you agree with the statement by circling the most appropriate rating. Please consider how your school has been during the prior school year (if applicable) when answering each item.

1. **My school has policies in place to promote the health and well-being of students.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
2. **My school has clear goals and expectations regarding the behavior of students.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
3. **Professionals in my school actively involve parents in delivering services for students.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
4. **Teachers in my school have difficulty identifying students with suspected mental health needs.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
5. **In my school, we have classroom-based or school-wide programs to prevent emotional and behavioral problems in students.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
6. **My school consistently promotes positive mental health.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
7. **In my school, the most common approach to accessing help for a student with a behavior problem is through the Special Education system.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
8. **Teachers in my school have effective classroom strategies for helping students who display behavioral problems.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
9. **In my school, there are clear strategies for helping students with suspected emotional problems.**	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**

10. My school actively encourages students to understand and respect the differences of others.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
11. My school has resources available to assist students when they display inappropriate behavior.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
12. My school has programs to prevent conflict and violence among students.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
13. Students and teachers feel safe in my school.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
14. In my school, there is a professional who is easily available to assist students when they present emotional and/or behavioral problems.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
15. Faculty and staff in my school receive training on differing needs of students.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
16. My school needs a better plan for dealing with students who are experiencing a mental health crisis.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
17. My school communicates with parents regarding mental health and behavioral issues of their children.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
18. My school does not have adequate resources to promote the health and well-being of students.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
19. In my school, I feel as though I am part of a team effort to best serve students with behavioral and emotional needs.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
20. In my school, students feel there is a professional they can turn to when they are dealing with a crisis or an emotional problem.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
21. In my school, teachers and administrators make efforts to understand the stresses experienced by students.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
22. In my school, there are in-school, out-of-classroom alternatives for helping students when they display behavioral problems.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
23. My school offers a full range of mental health services to students in both Special and Regular Education.	**Strongly agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**

If you taught at this school last school year, 2009/10, please answer the following:

Approximately how many times during the past school year have you referred a student for special services or evaluation because of behavioral or emotional problems?_____

Approximately how many times during the past school year have you participated in an IEP,504, or special accommodations process because of a student's behavioral or emotional problems?_____

When you encounter a student displaying emotion/behavioral problems to whom within the school building do you refer the student (Check up to three categories):

____Principal

____Other teaching staff (for example, support, consulting, aide, other teachers)

____Guidance Counselor

____Nurse or other Health staff

____Mental Health staff (for example, counselor, social worker, psychologist, therapist)

____Special programs in the school

____Other

____ (Please specify:) _____

Thank you for your help!

Behavioral Health Survey – Parent Version

We would like your opinion regarding the available behavioral health support resources for children at JBLM Schools. Please respond as openly as you can; results of this survey will be used to make recommendations about how to improve services in these areas. This survey should only take about 5-10 minutes, and your opinions will be completely confidential. You will not be identified in the results.

First, please tell us about yourself by circling the best response for you:

How long have you been located at this Installation? <1 month 1-6 months 7-12 months >12months

Where do you go for help when you need Behavioral Health services for your Child? School Counselor____ MAMC ____ Community Clinic ____ Tricare ____

Please answer the following questions about your Installation. Read each statement and tell us how much you agree with the statement by circling the most appropriate rating. Please consider your experiences during the prior year or period of time you have spent at this location, if less than a year, when answering each item.

I. Awareness of Behavioral Health Services for Military Children and Adolescents

1. I am aware that there are programs to help with Behavioral Health challenges such as anxiety, hyperactivity, aggression, worries, sadness ..... Strongly Agree Agree Neutral Disagree Strongly Disagree

2. Information about Behavioral Health Services for my Child is easily accessible to me ..... Strongly Agree Agree Neutral Disagree Strongly Disagree

II. Access to Behavioral Health Services for Military Children and Adolescents

1. Have you tried to locate or request a Behavioral Health related Evaluation for your Child within the past 12 months? Yes No

If Yes, please answer the following 2 questions (If No Skip):

How much time did it take to set up the 1st appointment? < 3 Days < 1 Week <1 Month >1 Month

How much time did it take to see the provider? <1 Week 1-2 Weeks 3-4 Weeks 1-2 Month >2 Months

The service was provided through: School Counselor _____ MAMC _____ Community Clinic _____ Others _____

2. Have you tried to locate or request Individual Counseling for your Child within the past 12 months? Yes No

If Yes, please answer the following 2 questions (If No Skip):

How much time did it take to confirm the 1st appointment? < 3 Days < 1 Week < 1 Month > 1 Month

How much time did it take to see the provider? < 1 Week 1-2 Weeks 3-4 Weeks 1-2 Month >2 Months

The service was provided through: School Counselor_____ MAMC _____ Community Clinic _____ Others _____

3. Have you tried to locate or request <u>Family Counseling</u> or <u>Parenting Coaching</u> services within the past 12 months? Yes No
If Yes, please answer the following 2 questions (If No Skip):

How much time did it take to confirm the 1st appointment?< 3 Days < 1 Week < 1 Month > 1 Month

How much time did it take to see the provider? <1 Week 1-2 Weeks 3-4 Weeks 1-2 Month >2 Months

The service was provided through: School Counselor_____ MAMC _____ Community Clinic _____ Others _____

4. Have you tried to locate or request a <u>Psychiatric Medication Management</u> service for your Child within the past 12 months? Yes No

If Yes, please answer the following 2 questions (If No Skip):

How much time did it take to confirm the 1st appointment? < 3 Days < 1 Week < 1 Month >1 Month

How much time did it take to see the provider? <Week 1-2 Weeks 3-4 Weeks 1-2 Month >2 Months

The service was provided through: School Counselor_____ MAMC_____ Community Clinic _____ Others _____

III. Satisfaction with **<u>Current</u>** Behavioral Health Providers/Service

1. My Child's school has a School Behavioral Health (SBH) program provided by MAMC providers ..... Yes No I don't' know

2. My Child is currently receiving Behavioral Health service Yes No (If "no" skip to the end)

3. My Child's Behavioral Health service is provided through: School _____ MAMC _____ Community Clinic _____

Others _____ School Behavioral Health (SBH) _____

4. The provider listened to my concerns Strongly Agree Agree Neutral Disagree Strongly Disagree

5. The provider answered all my questions Strongly Agree Agree Neutral Disagree Strongly Disagree

6. The provider explained my Child's symptoms / disorders Strongly Agree Agree Neutral Disagree Strongly Disagree

7. The provider spent enough time with me (and my child) Strongly Agree Agree Neutral Disagree Strongly Disagree

8. I feel involved with my child's Behavioral Health care Strongly Agree Agree Neutral Disagree Strongly Disagree

9. The service was convenient for my family to access Strongly Agree Agree Neutral Disagree Strongly Disagree

10. In general I'm satisfied with my child's Behavioral Health service. Strongly Agree Agree Neutral Disagree Strongly Disagree

COMMENTS:

INFORMATION PAPER – MAY 2010

CHILD, ADOLESCENT AND FAMILY BEHAVIORAL HEALTH OFFICE (CAF-BHO)

School Behavioral Health (SBH) Program

1. Overview

a. School Behavioral Health (SBH) Programs provide cost-effective, comprehensive behavioral health (BH) services to support military Children, their Families, and the Army Community in schools. The program utilizes a Public Health Model, providing a continuum of care from prevention through early intervention to behavioral health treatment. The overarching goal is to facilitate access to care by embedding BH within the school setting, and to provide state of the art prevention, intervention, evaluation, and treatment through standardization of school behavioral health services and programs. Services are directed at improving academic achievement, maximizing wellness and resilience of Army Children and Families, and ultimately promoting optimal military readiness.

b. The SBH Program provides direct and non-direct clinical services in the schools. A full array of behavioral healthcare services are provided with BH staff fully integrated within the School and Community. Again, care is provided along a continuum, from prevention and health promotion to intensive behavioral health intervention.

c. Non-direct care services emphasize prevention and resiliency building through educational programs available to Students, Families, and the Community promoting "help-seeking behavior", reducing stigma, optimizing resiliency/well-being, and providing support and coping strategies for dealing with deployment and other military stressors.

d. Direct care programs include screening, early intervention, evaluation, and treatment. Early intervention strategies include a variety of programs focused on adjustment issues and coping with deployment and other military stressors. More intensive interventions include counseling, psychological interventions, and medication management for Children and Families as needed based on a thorough evaluation. Services may include individual, group, and/or family treatments. The goal is reduction/elimination of psychological symptoms and improved academic and behavioral functioning. Recognition of the unique stressors of the military lifestyle guide most clinical practices.

2. Target Population

The current target population is Children of Active Duty Members attending on-post schools (K-12). Pilot programs have been proposed for on-post Child Development Centers (0-5), as well as off-post schools.

3. Program Scope and Capacity

a. SBH Programs have been implemented at the following installations: Schofield Barracks, HI, Ft. Campbell, KY, Joint Base Lewis McChord, WA, Ft. Meade, MD, US Army Garrison (USAG) Grafenwoehr, Germany, USAG Baumholder, Germany and Fort Carson, CO.

b. Current SBH Programs are able to provide BH services to eligible children attending the school in which the program exists. Current SBH Programs meet or exceed the TRICARE BH access standards due to onsite accessibility and availability of clinical providers embedded within the school setting.

c. Where SBH programs exist, the clinical scope of the program meets most of the targeted children's behavioral health care needs. However, on-post School Behavioral Health Programs care for only a small percentage of Military Children impacted by the on-going war. Favorable policy decisions, command support, and adequate funding would facilitate proliferation of SBH Programs (K-12) across additional Army deployment platforms, as well as expansion to Child Development Centers and off-post schools, thus providing SBH care to a greater number of Army Children and Families.

Form 1

Student Concern Form
Teacher completes

Date: _____ Student of concern: _____

Teacher: _____ School: _____

1. I am concerned in the following area(s):

___ Academics: (explain) _____

___ Behavior: (explain) _____
(Please bring documentation such as # of think times, when they are occurring, lunch interventions, etc.)

___ Other: (explain) _____

2. I have called the parents on this/these dates: _____

Results of parent conversation:
_____
_____
_____
_____

3. Do you know if the student has any health concerns, medications, etc?
_____
_____

4. Current Data:
- ❖ DIBELS Scores: Please attach most recent results
- ❖ Math Scores:

- ❖ Homework/Work Completion (what percentage of work do they complete or turn in?)

- ❖ Current Grades:

5. Current interventions or accommodations in place: Attach 504 or IEP documentation.

Intervention or Accommodation	Results

Child Concern Form
Parent completes

Form 2

Date: _____ Child's name: _____

Grade: _____ Teacher: _____

A: I am concerned about my child in the following area(s):

1. ____ Academics: (explain) _____
2. ____ Behavior: (explain) _____
3. ____Emotional Wellbeing (explain) _____
4. ____Social Skills/interactions (explain)_____

(Please check those items which apply to your child)

1) _____ Hyperactivity _____ Poor attention _____ Impulsive
2) _____ Extremely aggressive (verbal or physical)
3) _____ Severe tantrums; meltdowns
4) _____ Anxious; fearful; worried
5) _____ Depressed; sad; tearful
6) _____ Withdrawn; isolated
7) _____ Abnormal eye contact (too much, too little)
8) _____ Head banging, rocking
9) _____ Sleep problems
10) _____ Toileting problems (day or nighttime incontinence)
11) Other _____

I would like to have professional behavioral health help for my child at school:

1) ___ Someone checking in with my child from time to time
2) ___ A psychiatric evaluation for my child
3) ___ I think my child needs intensive individual therapy.
4) ___ My child (who already has a psychiatric diagnosis) needs a medication prescriber.
5) Other _____

Please fill this form and bring it to your child's teacher/principal. Thank you.

Parent's name _____

Contact phone number: _____

DEPARTMENT OF THE ARMY
HEADQUARTERS, MADIGAN ARMY MEDICAL CENTER
9040 FITZSIMMONS AVE.
TACOMA, WA 98431

Policy on Patient Confidentiality And Privacy

1. General Policy:

Confidentiality is an essential part of psychiatric care. The Hippocratic Oath and the American Psychiatric Association ethical guidelines both emphasize the importance of silence about professional secrets. It is our policy to do everything possible to protect your privacy. Confidential medical information is handled according to the requirements of AR 40-66, Medical Record Administration; AR 340-21 The Army Privacy Program; DOD Directive 6490.4; and MAMC Legal Office Memorandum, dated January 1995. In general, only the information necessary to satisfy legal requirements will be released. It is important to note that confidentiality is not absolute. Please read carefully the limits to patient privacy and confidentiality listed below.

2. Limits to Confidentiality:

A. Legal Matters: Federal, state and military regulations do not allow for absolute confidentiality in physician-patient relationships. Therefore, if you are involved in a trial or a legal investigation, your health care provider and mental health record could be subpoenaed. Your provider could be compelled to reveal information about you.

B. Safety: If there is a question in the mind of the provider about your safety or your child's safety, the provider may take action such as hospitalization or civil commitment. In the course of this action, information about you or your child may be revealed to others. Also, if you or your child threatens to harm another person, federal laws require that the provider -notify and warn that person, even if you do not want that person notified. Finally, any medical conditions such as epilepsy or Alzheimer's Disease that may impair your safe operation of an automobile must be reported to the Department of Motor Vehicles.

C. Abuse: Federal and state laws as well as DOD regulations are very specific about the requirements to report physical or sexual abuse of Children, and certain types of abuse of spouses and the elderly.

D. Improvement of Care: In many cases, information about you may be reviewed and discussed by your provider with other health care providers. The purpose of these discussions is to improve your medical care. Also, "peer review" of your medical records by a colleague takes place on a routine basis for the purpose of checking on the quality of care being provided.

If you have any questions about any of these issues, please discuss them with your provider.

_____ _____

Student's Name Your Relationship to Student

_____ _____

Signature Date

	DEPARTMENT OF THE ARMY **HEADQUARTERS, MADIGAN ARMY MEDICAL ENTER** **9040 FITZSIMMONS AVE.** **TACOMA, WA 98431**	**CONSENT FOR SERVICES AND RELEASE OF INFORMATION**

1. I, _____, the parent or legal guardian of _____,
Print Name Full Name of Student

born on_____, request Clover Park School District of WA state to provide mental health services to the
Date of Birth of Student

above referenced child, who is presently attending _____.
Name of School

2. I give my permission to School Behavioral Health Services, Madigan Army Medical Center. 9913-A MAMC ANNEX, Ramp 2, Tacoma, WA 98431, to release health care information, including psychotherapy information, regarding my child, acquired during said mental health services to:

Clover Park School District of WA state

_____
(School or District Office)

_____
(city) (State) (zip code)

3. In order to facilitate mental health treatment of my child, I give my permission to Clover Park School District of WA state to disclose data originating from school records to School Behavioral Health, Madigan Army Medical Center, 9913-A MAMC ANNEX, Ramp 2, Tacoma, WA 98431.

_____ _____
Signature of parent or legal guardian Date

_____ _____
Name of Student Date

_____
Telephone

PSYCHOTROPIC MEDICATION CONSENT

_____ _____

Patient's Name & Sponsor's SSN Date

Psychotropic medications are medicines that are used in the treatment of emotional, behavioral and thinking problems. Each class of medicines has its indications for use, expected benefits and side effects. Side effects may be uncomfortable, or in rare circumstances, dangerous. Many of the side effects are dosage-related and the physician will attempt to find a dosage level that is beneficial yet produces the least side effects. If one medication in a particular class does not help the condition or if it produces disturbing side effects, treatment with another medicine in the class may be more successful.

If at any time you disagree with the treatment plan, you may discuss it with the physician. If you have any questions regarding the information presented here, or any aspect of the treatment, please ask the treating physician.

My physician met with me, and we talked about the following:

1. The nature of my medical problem and the reasons why medication is being recommended.
2. The likelihood of my improving with or without such medication and the reasonable alternative treatments available.
3. The type of medication being recommended below.
4. The dosage range and frequency of this medication (including possible additional doses as needed); the method of taking this medication; and the probable duration I would need to take this medication.
5. The possibility that this medication may cause side effects to include the most common and most severe side effects.
6. The possible effects after taking medication for a long time (usually more than three months). Such side effects may include persistent involuntary movement of the head, hands, feet and torso, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after medications have been discontinued.

I will notify the physician if I become pregnant, plan pregnancy or plan to breast feed. I understand that this medication may not be safe under these circumstances.

I understand that because of possible drowsiness or loss of muscle coordination, my ability to drive, operate machinery or perform other skilled tasks may be impaired. This effect may worsen with alcohol or other substances.

I have read this form, and I understand it.

I understand that I have the right to refuse medication recommended to me by telling my doctor at any time. I consent to take the medication up to the dosage noted below:

MEDICATION	MAXIMUM DAILY DOSAGE	INITIAL PATIENT	INITIAL PARENT/GUARDIAN	PHYSICIAN	DATE

_____ _____ _____

Patient Signature Parent/Guardian Signature Physician Signature

Parent or Guardian to complete Items #1-4, #6, #8-13 and Sponsor info in last box.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information. This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	[X] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
School Behavioral Health Madigan Army Medical Center	MAMC Annex, 9913-A Ramp 2 Tacoma, WA 98431
c. TELEPHONE *(Include Area Code)* (253)968-4723	d. FAX *(Include Area Code)* (253)968-4747

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE	[X] CONTINUED MEDICAL CARE	[X] SCHOOL	[X] OTHER *(Specify)*
[ ] INSURANCE	[ ] RETIREMENT/SEPARATION	[ ] LEGAL	Behavioral Health/ Developmental Assessment

8. INFORMATION TO BE RELEASED

_____ Inpatient Discharge Summary	_____ Physician Progress Notes	_____ Laboratory Reports
_____ Behavioral Health Evaluation	_____ Specialty Consultation Reports	_____ Psychological & Educational Testing
_____ History & Physical Examination	_____ Developmental Evaluation	_____ Medication Orders / Lists
	_____ EFMP Profile / Documentation	_____ Other

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
	[ ]	[ ] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. ADDITIONAL INFORMATION:	
By signing above, I also understand that the medical records and information to be released may contain information pertaining to behavioral health, drug and/or alcohol related treatment, and may also contain confidential HIV (AIDS) related information, including test results. This disclosure of records and information authorized herein is required for assessment, diagnosis, and/or treatment of the above named individual.	**SPONSOR NAME:** **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

DD FORM 2870, DEC 2003 APD PE v1.01ES

SCHOOL BEHAVIORAL HEALTH
INTAKE INFORAMTION

I. IDENTIFYING DATA SCHOOL:

CHILD: _____ Date of Birth: _____
Last Name First MI mm/dd/yyyy

Email Address:_____ Cell Phone: _____

Home Address: _____ Home Phone: _____

_____ Age: _____ Sex: M F

Date Moved to Installation: _____ Date of Anticipated Move From Installation: _____

SPONSOR: _____ Date of Birth: _____ Age: _____

Relationship to Patient: _____ Natural ____ Step ____ Adoptive ____

Branch of Service: _____ MOS:_____ Pay Grade: _____

Educational Level: _____ Religion, spiritual beliefs and/or culture: _____

Social Security No.: _____ Duty Phone: _____

SPOUSE: _____ Date of Birth: _____ Age: _____

Relationship to Patient: _____ Natural ____ Step ____ Adoptive ____

Educational Level: _____ Religion, spiritual beliefs and/or culture: _____

Occupation: _____ Work Phone: _____

IF ALSO ACTIVE DUTY: Branch of Service: _____ MOS: _____ Pay Grade: _____

Social Security No.: _____ Duty Phone: _____

SIBLINGS

Name	Date of Birth	Sex	Full/Step/Half/Other

Who presently lives in the home? _____

II. PRESENTING PROBLEMS

Please describe the presenting problems or situations with which you are requesting assistance. If additional space is needed, uses plain paper for continuation:

_____

_____

_____

_____

_____

Some items of behavior are listed below. We are interested in knowing which of these your child has displayed. Check (X) those items which apply to your child.

PLEASE BRIEFLY EXPLAIN THE ITEMS RELATING TO YOUR CHILD:

1. _____ Eating problems _____
2. _____ Sleeping problems _____
3. _____ Hyperactivity _____
4. _____ Poor attention _____
5. _____ Oppositional _____
6. _____ Aggressive _____
7. _____ Tantrums _____
8. _____ Impulsive _____
9. _____ Anxious, fearful _____
10. _____ Depressed _____
11. _____ Fussy, irritable, crying _____
12. _____ Repetitive, checking behavior/rituals _____
13. _____ Eye contact _____
14. _____ Headbanging, rocking _____
15. _____ Sexualized behavior _____
16. _____ Abuse – physical _____
17. _____ Abuse – sexual _____
18. _____ Neglect _____
19. _____ Trauma to child _____
20. _____ Substance Use _____
21. Alcohol _____ Tobacco _____ Illicit Drugs _____ Other _____

_____

22. _____

III. SCHOOL HISTORY (Includes daycare, preschool, kindergarten and above)

Current School: _____ Grade:_____ School Phone: _____

When did the child enter school? _____ How many schools has child attended? _____

Describe child's attitude towards the school: _____

Has the child had emotional or behavioral problems at school? Yes _____ No _____

If yes, describe: _____

_____

Has the child had any learning problems? Yes _____ No _____

If yes, describe: _____

_____

Has the child been assessed by this/other school system previously? Yes_____ No_____

If yes, what type of assessment was completed: Speech_____ Cognitive_____ Behavioral_____

Psychological_____ Other_____

IV: BEHAVIORAL HEALTH HISTORY

Is the child currently seeing a counselor? No__ Yes____: Provider: _____ Phone: _____

Currently taking any psychiatric medication? No __ Yes __ : Prescriber: _____ Phone: _____

Medication and doses: _____

Previous behavioral health treatment:

Inpatient: No ___ Yes ___; Date : _____ Location: _____

Outpatient: Counseling No ___ Yes ____ Provider:_____

Prior Medication: _____

Medication Side effect: _____

History of self-harm or suicidal comments/behavior or harming others:

Was your child ever enrolled in EFMP? Yes _____ Last update on EFMP _____

No _____

V: MEDICAL HISTORY

Has the child ever been hospitalized? Yes _____ No _____ If yes, give age and describe circumstances:_____

Does the child have any medical illnesses? No _____ Yes: _____ Allergy: _____

VI: BIRTH AND DEVELOPMENTAL HISTORY:

Was the child born full term _____ / premature _____

Was the mother using alcohol or street drugs during pregnancy: No __ Not sure ___ Yes _____

Did the child meet developmental milestones on time? Yes _____ No _____

If delayed: Spoke at age _____ Walked at age _____ Toilet Trained at age _____

VII: FAMILY MEDICAL & PSYCHIATRIC HISTORY:

Mother: Medical illness: No ____ Yes: _____

Psychiatric diagnoses: No __ Yes : _____ Substance use: _____

Father: Medical illness: No ____ Yes : _____

Psychiatric diagnoses: No __ Yes : _____ Substance use: _____

Other family members: Medical: _____ Psychiatric: _____

Suicidal attempts in the family: _____

VIII: PARENTS DEPLOYMENT HISTORY:

Month/Year – Month/Year	Location (Place of Duty)	Who did your child live with during that time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School Mental Health Quality Assessment Questionnaire (SMHQAQ)*

Center for School Mental Health Analysis and Action
October, 2006

Part of a research grant, *Enhancing Quality in Expanded School Mental Health.* National Institute of Mental Health, U.S. Department of Health and Human Services, #1R01MH71015-01A1; 2003-2006.

Please answer each item that follows based on your current practice in school. *Please select the number that best reflects the degree that the item is developed and/or implemented. Thank you.*

Principle 1: All youth and families are able to access appropriate care regardless of their ability to pay.	not at all in place					fully in place
ACCESS TO CARE						
1) When indicated, do you provide case management assistance to students and families to assist them in obtaining health insurance or to facilitate enrollment in programs for which they are eligible?	1	2	3	4	5	6
FUNDING						
2) Are you engaged in activities that may bring resources or financial support into the school mental health program?	1	2	3	4	5	6
Principle 2: Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.	not at all in place					fully in place
NEEDS ASSESSMENT						
3) Have you conducted assessments on common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse)?	1	2	3	4	5	6
4) Have you held meetings with students, parents, and teaching staff to ask them about their needs and to ask them for their recommendations for actions by school mental health staff?	1	2	3	4	5	6
ADDRESSING NEEDS AND STRENGTHS						
5) Do you have services in place to help students contend with common risk and stress factors?	1	2	3	4	5	6
6) Are you matching your services to the presenting needs and strengths of students/families after initial assessment?	1	2	3	4	5	6
Principle 3: Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.	not at all in place					fully in place
EVIDENCE-BASED PRACTICE: SCREENING, ASSESSMENT, AND INTERVENTION						
7) Do you receive ongoing training and supervision on effective diagnosis, treatment planning and implementation, and subsequent clinical decision-making?	1	2	3	4	5	6
8) Do you conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems?	1	2	3	4	5	6
9) Do you continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems?	1	2	3	4	5	6
10) Is there a clear and effective protocol to assist your clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)?	1	2	3	4	5	6
11) Are you actively using the evidence-base (practices and programs) of what works in child and adolescent mental health to guide your preventive and clinical interventions?	1	2	3	4	5	6

Principle 4: Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.	not at all in place					fully in place
STAKEHOLDER INVOLVEMENT AND FEEDBACK						
12) Have you helped your school develop an advisory board (including youth, families, administrators, educators, school health staff, community leaders) for its mental health programs?	1	2	3	4	5	6
13) Do you collaborate closely with your school administrator and offer numerous opportunities for recommendations, feedback, and involvement in program development and implementation?						
14) Do you participate in methods or activities (e.g., meetings, focus groups, surveys) to obtain feedback on an ongoing basis from key stakeholders on how the program is functioning and how it can be improved?	1	2	3	4	5	6
15) Do you engage in efforts to ensure that stakeholder ideas and recommendations are actually implemented in a timely manner?	1	2	3	4	5	6
16) Are you providing training and educational activities for families, teachers and other stakeholder groups based on their recommendations and feedback?	1	2	3	4	5	6
Principle 5: Quality assessment and improvement activities continually guide and provide feedback to the program.	not at all in place					fully in place
QUALITY ASSESSMENT AND IMPROVEMENT						
17) Are your efforts and activities being guided by an active and effective quality assessment and improvement plan that other school mental health clinicians and stakeholders (school staff, families, community) are aware of?	1	2	3	4	5	6
18) Have you been well trained in paperwork requirements for your program, and do your records clearly reflect delineated policies and procedures?	1	2	3	4	5	6
19) Are you ensuring that families are meaningfully involved in treatment planning and ongoing therapy efforts?	1	2	3	4	5	6
20) Are peer review mechanisms in place for you to receive feedback from other mental health staff on the way you handle cases and/or implement preventive and clinical interventions?	1	2	3	4	5	6
21) Are you actively using an evaluation plan that provides measurable results to and helps to improve your preventive and clinical intervention efforts?	1	2	3	4	5	6
22) Are you sharing positive and negative findings from the evaluation of your services with youth, families, school staff and other stakeholders?	1	2	3	4	5	6
Principle 6: A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.	not at all in place					fully in place
CONTINUUM OF CARE						
23) Do you offer activities promoting school-wide mental health?	1	2	3	4	5	6
24) Are you actively involved in developing and implementing training and educational activities for educators on the identification, referral, and behavior management of social/emotional/behavioral problems in students?	1	2	3	4	5	6
25) Do you offer group, classroom, and school-wide prevention activities?	1	2	3	4	5	6
26) Do you offer intensive treatment services to youth and families including individual, group, and family therapy?	1	2	3	4	5	6
27) Are you able to continue to have mentoring relationships with students who no longer present serious problems?	1	2	3	4	5	6
REFERRAL PROCESS						
28) Are your referral procedures being well utilized by educators, other mental health staff, health staff, administrators, parents and students?	1	2	3	4	5	6
29) Do you promptly screen/assess all students who have been referred for services?	1	2	3	4	5	6

Principle 7: Staff holds to high ethical standards, is committed to children, adolescents, and families, and displays an energetic, flexible, responsive and proactive style in delivering services.	not at all in place					fully in place
CLINICIAN TRAINING, SUPPORT, AND SERVICE DELIVERY						
30) Do you feel sufficiently trained, supported, and supervised to handle the unique demands of school-based practice in an ethical and effective manner?	1	2	3	4	5	6
31) Are the services you provide characterized by a flexible, proactive approach that enables youth and families in need to be served as rapidly as possible?	1	2	3	4	5	6
Principle 8: Staff is respectful of, and competently addresses developmental, cultural, and personal differences among students, families and staff.	not at all in place					fully in place
COMPETENTLY ADDRESSING DEVELOPMENTAL, CULTURAL, AND PERSONAL DIFFERENCES						
32) Are you receiving regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds?	1	2	3	4	5	6
33) Does your caseload reflect the diversity of the school population?	1	2	3	4	5	6
34) Are you making efforts to ensure that your school mental health program and services are welcoming and respect the students and families served?	1	2	3	4	5	6
35) Are key stakeholders who provide ongoing guidance to your school mental health program diverse in terms of gender, race/ethnicity, and personal/cultural background?	1	2	3	4	5	6
Principle 9: Staff builds and maintains strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.	not at all in place					fully in place
INTERDISCIPLINARY COLLABORATION AND COMMUNICATION						
36) Are you helping to coordinate mental health efforts in the school to ensure that youth who need services receive them, while avoiding service duplication?	1	2	3	4	5	6
37) Are you using or helping to develop communication mechanisms to ensure that information is appropriately shared and that student and family confidentiality is protected?	1	2	3	4	5	6
38) Do you actively collaborate with other professionals in your school (other health/mental health providers, educators, administrators)?	1	2	3	4	5	6
Principle 10: Mental health programs in the school are coordinated with related programs in other community settings.	not at all in place					fully in place
COMMUNITY COORDINATION						
39) Are you knowledgeable about existing mental health and related resources for students in the school and community and is this information readily available in a directory that can be broadly shared within the school?	1	2	3	4	5	6
40) Are you working closely with other community health and mental health providers and programs to improve cross-referrals, enhance linkages, and coordinate and expand resources?	1	2	3	4	5	6

*Mark D. Weist[1], Sharon Stephan, Nancy Lever, Elizabeth Moore, & Krystal Lewis
[1] Center for School Mental Health Analysis & Action, University of Maryland School of Medicine, 737 W. Lombard Street, 4th floor, Baltimore, MD 21201; 410-706-0980; mweist@psych.umaryland.edu

Strengths and Difficulties Questionnaire

P 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

Strengths and Difficulties Questionnaire P 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the last six months.

Your child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example CD's, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees chores or homework through to the end	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

Signature ..... Date .....

Mother/Father/Other (please specify:)

Thank you very much for your help

School Behavioral Health Comment Card

Provider Seen N/A

Management of my family's stress: ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Relationships in my family ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Emotional functioning of the active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Emotional functioning of the non-active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Emotional functioning of my child(ren):
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Management of home/work responsibilities for the active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Management of home/work responsibilities for the non-active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Adjustment to deployment for the active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Adjustment to deployment for the non-active duty parent in my family:
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Adjustment to deployment for my child(ren):
○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Customer Service:

Facility Appearance ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Employee/Staff Attitude ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Timeliness of Service ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Hours of Service ○ Excellent ○ Good ○ OK ○ Poor ○ Awful ◉ N/A

Did the product or service meet your needs? ○ Yes ○ No ◉ N/A

Satisfaction:

Were you satisfied with your experience at this office / facility? ○ Yes ○ No ◉ N/A

Comments & Recommendations for Improvement: (optional)
CAUTION: Do NOT enter sensitive or personally identifying information in your comments. Text comments may be viewed by several authorized persons involved or not involved in your specific issue. We welcome your feedback.